Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **South Carolina** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Head and Spinal Cord Injury (HASCI) Waiver

C. Waiver Number: SC.0284
Original Base Waiver Number: SC.0284.

D. Amendment Number: SC.0284.R03.01

E. Proposed Effective Date: *(mm/dd/yy)*
01/01/10

Approved Effective Date: 01/01/10
Approved Effective Date of Waiver being Amended: 07/01/08

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
South Carolina is seeking to amend the South Carolina Head and Spinal Cord Injury Waiver due to current state budget reductions at the South Carolina Department of Disabilities and Special Needs (SCDDSN) that places limits on attendant care and nursing services.

Attendant Care service limits will allow up to 49 hours per week on a routine basis(reduced from 56 hours a week).

Attendant Care combined with HASCI Waiver Nursing, the combined services, whether routine or short term, may not exceed 10 hours per day (nursing limits allow up to 60 hours per week of LPN or 45 hours per week of RN).

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	5.I, 7.A, Quality Improvement
☑ Appendix A – Waiver Administration and Operation	3, 7, Quality Improvement
☑ Appendix B – Participant Access and Eligibility	B4.A-2, B6.J, Quality Improv
☑ Appendix C – Participant Services	C.3, Quality Improvement
☑ Appendix D – Participant Centered Service Planning and Delivery	Quality Improvement
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☑ Appendix G – Participant Safeguards	G-1.B, Quality Improvement
☑ Appendix H	Quality Improvement
☑ Appendix I – Financial Accountability	Quality Improvement
☑ Appendix J – Cost-Neutrality Demonstration	J-1, J-2ciii, J-2civ, J-2d,

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☑ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
The focus of this amendment is to revise service specifications in the services of nursing and attendant care. The State is also taking this opportunity to convert the application into the 3.5 version of the web-based application and make minor administrative changes in the document to ensure it is up to date since its renewal in 2008.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **South Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Head and Spinal Cord Injury (HASCI) Waiver

C. Type of Request: amendment

Original Base Waiver Number: SC.0284
Waiver Number: SC.0284.R03.01
Draft ID: SC.09.03.01

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/08
Approved Effective Date of Waiver being Amended: 07/01/08

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
South Carolina is seeking to renew the South Carolina Head and Spinal Cord Injury Waiver. This Waiver will serve persons with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive degenerative illness, disease, dementia or a neurological disorder related to the aging. All persons must meet either the Nursing Facility level of care or the ICF-MR level of care criteria.

Administrative authority for this Waiver is retained by the South Carolina Department of Health and Human Services (DHHS). The South Carolina Department of Disabilities and Special Needs (DDSN) perform Waiver operations under a memorandum of agreement and service contract with DHHS. DDSN has the operational responsibility for ensuring that participants are aware of their options under this Waiver. DDSN utilizes an organized health care delivery system that includes both county Disability and Special Need Boards and private providers as Waiver service providers. Services in this Waiver are provided at the local level mainly through a traditional service delivery system. This Waiver does have a participant-directed service that allows individuals or responsible party to direct their own attendant care services if they chose this option.

The services offered in this Waiver are meant to prevent and/or delay institutionalization in a nursing home or ICF/MR. This Waiver reflects the State's commitment to offer viable community options to institutional placement.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually)

of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The State secures public input into the development of the waiver through a multi-step process involving: a random sample survey of waiver participants, multi-website survey for the public, a public meeting, SCDDSN Commission review and approval, and SCDHHS Medical Care Advisory Committee review and consent.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Atwood
First Name:	Anita

Title:	Program Coordinator II
Agency:	Department of Health and Human Services
Address:	PO Box 8206
Address 2:	
City:	Columbia
State:	**South Carolina**
Zip:	29202
Phone:	(803) 898-2702 **Ext:** ☐ **TTY**
Fax:	(803) 255-8209
E-mail:	Atwood@scdhhs.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Veldheer
First Name:	Linda
Title:	Director, Head and Spinal Cord Injury Division
Agency:	Department of Disabilities and Special Needs
Address:	PO Box 4706
Address 2:	Harden St. Ext.
City:	Columbia
State:	**South Carolina**
Zip:	29240
Phone:	(803) 898-9600 **Ext:** ☐ **TTY**
Fax:	(803) 898-9653
E-mail:	LVeldheer@ddsn.sc.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Emma Forkner
	State Medicaid Director or Designee
Submission Date:	Nov 17, 2009

Last Name:	Forkner

First Name:	Emma
Title:	Director
Agency:	SC Department of Health and Human Services
Address:	PO Box 8206
Address 2:	
City:	Columbia
State:	**South Carolina**
Zip:	29202
Phone:	(803) 898-2500
Fax:	(803) 255-8235
E-mail:	Forkner@scdhhs.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not Applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

     - **The Medical Assistance Unit.**

       Specify the unit name:

       (Do not complete item A-2)

     - **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

       Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

       (Complete item A-2-a).

   - **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
The Department of Disabilities and Special Needs

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
SCDHHS and SCDDSN have a Memorandum of Agreement (MOA) to ensure an understanding between agencies regarding the operation and administration of the HASCI Waiver. The MOA delineates how the waiver will be operated by SCDDSN under the supervision of SCDHHS, who will exercise administrative supervision, as well as, approve waiver polices, rules and regulations. SCDHHS has the final authority regarding administrative matters. The MOA specifies the following waiver functions between agencies:
• Communication
• Coordination
• Level of Care
• Quality Management
• Medicaid Management Information System
• Fiscal Administration

The MOA and the service contract is reviewed and updated at least every three (3) years and amended as necessary.

SCDHHS and SCDDSN also have a waiver service contract to outline the requirements and responsibilities for the provision of waiver services by the operating agency. The contract specifies the following:
• Definition of Terms
• Waiver Service Definitions and Scopes of Services
• Provider Qualifications
• Waiver Service Reimbursement Rates
• Conditions for Reimbursement
• Audits and Records
• Termination of Contract
Services provided in this waiver will be done in coordination with the child's family, waiver service provider, case manager and the Local Education Agency (LEA). The purpose of this coordination is to avoid duplication and ensure that identified needs are met.

SCDHHS utilizes various quality assurance methods to evaluate the operating agency's compliance with the terms and conditions established in the MOA and service contract, with special focus on SCDDSN's performance of assigned waiver operational and administrative functions in accordance with waiver requirements.

SCDHHS uses a CMS approved Quality Improvement Organization (QIO), quality assurance staff, and other agency staff to continuously evaluate the operating agency's quality management processes to ensure compliance. The following describes the roles of each entity:
• QIO conducts monthly validation reviews of a representative sample of initial ICF/MR level of care determinations performed by SCDDSN. Monthly reports are produced and shared with SCDDSN, who is responsible for remedial actions as necessary in a timely manner. Quarterly summary reports are also created with trending and analysis of data, and recommendations for improvement.
• Quality Assurance (QA) Staff conducts periodic quality assurance and compliance validation reviews of a sample of participant case records and personnel files of SCDDSN service providers. These reviews focus on the CMS quality assurance framework, indicators, and performance measures. After each review, a report of findings is provided to SCDDSN, who is required to develop and implement a remediation plan, if applicable within a required timeframe.
• QA Staff utilize other systems such as Medicaid Management Information Systems (MMIS),and MedStat Advantage to monitor quality and compliance with waiver standards. The use and results of these discovery methods may require special focus reviews. In such instances, a report of findings is provided to SCDDSN for remediation purposes.
• Other SCDHHS Staff conducts utilization reviews, investigate potential fraud, and other requested focused reviews of the operating agency as warranted. A report of findings is produced and provided to SCDDSN for remedial action (s) as necessary.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   1. DDSN contracts with the USC School of Medicine: The School of Medicine currently performs quality assurance of the operational function of the University Affiliated Program (UAP) Attendant Care Program as an option of self-directed or designated responsible party-directed attendant care services.

   2. DDSN contracts with the USC School of Medicine, Center for Disability Resources: This contract provides for the single point of preliminary intake and eligibility screening for all individuals seeking services through the Head and Spinal Cord Injury Division.

   3. DDSN contracts with a CMS approved QIO: This contract is for oversight and review of all Waiver services and providers participating in either the HASCI or MR/RD Waiver.

   4. DHHS contracts with a CMS approved QIO: This entity reviews initial ICF/MR levels of care preformed by DDSN. This entity provides monthly reports and quarterly summaries of the outcome of their review process.

   5. DHHS may periodically contract with an independent quality management entity to perform focused evaluations.

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ○ **Not applicable**

   ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
   Check each that applies:

   ☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the

Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

1. DHHS contracts with DDSN for the operation of the Head and Spinal Cord Injury Waiver.

2. DDSN contracts with its local Disabilities and Special Needs (DSN) Board providers. Service coordination staff at the local Disabilities and Special Needs Board prepares the Plans of Service and complete reevaluations of NF and ICF/MR levels of care.

3. DDSN contracts with the Jasper Disabilities and Special Needs (DSN) Board which operates as the fiscal agent of the UAP Attendant Care Program.

☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Private providers and other approved/qualified providers. Service coordination staff prepares the Support Plan and complete reevaluations for NF and ICF/MR levels of care.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Department of Health and Human Services and the Department of Disabilities and Special Needs jointly share the responsibility of assessing the performance of contracted local/regional non-state entities in conducting Waiver operational and administrative functions. The Jasper County Board of Disabilities and Special Needs (DSN) operates as the fiscal agent of the University Affiliated Project (UAP) Attendant Care Program. DDSN contracts with DSN Boards and other qualified/approved providers and the providers are assessed annually. Upon request, DHHS Medicaid Program Integrity Division also conducts reviews.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
SCDHHS and the SCDDSN jointly share responsibility in assessing the performance of contracted and local/regional non-state entities in conducting waiver administrative and operational functions. The MOA sets forth the QA responsibilities for both agencies.

SCDHHS utilizes both a quality assurance contractor and its Medicaid Program Integrity Unit (MPI) to oversee and review the operational functions of SCDDSN. SCDHHS completes quality assurance reviews of providers and submits findings to SCDDSN who reviews the findings and provides technical follow-up and ensures a corrective action is provided as required by SCDHHS.

SCDDSN contracts with a QIO to assess the local Disabilities and Special Needs Boards (DSN) and other qualified/approved providers at least annually. SCDDSN also conducts reviews and provides technical assistance to providers of PDD waiver services. Following reviews, the QIO issues a comprehensive Report of Findings to the local DSN Board/private provider and to SCDDSN. SCDDSN shares the Report of Findings with SCDHHS. SCDHHS reviews these reports and will conduct independent reviews to validate the findings of the SCDDSN QIO. Upon request, MPI conducts provider reviews.

SCDDSN Internal Audit Division also conducts special request audits, investigates fraud cases, provides training and technical assistance and reviews the audited financial statements of the local DSN Boards and other qualified/approved private providers. All DSN Boards and qualified/private providers are required to have a financial audit conducted annually by a CPA firm.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☑	☑
Waiver enrollment managed against approved limits	☑	☑	☑	☑
Waiver expenditures managed against approved levels	☑	☑	☑	☑
Level of care evaluation	☑	☑	☑	☑
Review of Participant service plans	☑	☑	☑	☑
Prior authorization of waiver services	☑	☐	☑	☑
Utilization management	☑	☑	☑	☑
Qualified provider enrollment	☑	☑	☐	☐
Execution of Medicaid provider agreements	☑	☑	☐	☐
Establishment of a statewide rate methodology	☑	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each

source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Presence of an MOA that includes designated functions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS/DDSN MOA document

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☑ **Other** Specify: MOA document is updated every 3 years or more often as needed; an MOA report card evaluation is produced quarterly	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify: [ ]	☐ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Presence of a service contract that includes requirements and responsibilities for the provision of services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS/DDSN service contract

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = ☐ **Stratified** Describe Group:
☐ **Other** Specify:	☐ **Annually**	
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Service Contract is revised/updated every 3 years or more often as needed; a service contract report card evaluation is produced quarterly.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of NF & ICF/MR level of care validation reviews.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QIO/QA reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: DHHS QIO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: DHHS QIO	☐ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Proportion of quality assurance and compliance validation reviews.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Report of Findings

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of special focus reviews, utilization reviews, and/or fraud investigations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Report of Findings

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Sampling is determined by evidence warranting a special review and/or investigation
	☑ **Other** Specify: Reviews and/or investigations are conducted as warranted	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify: [ ]	☐ **Annually**
	☑ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
Aggregated discovery and remediation reports submitted by the operating agency, relating to each of the operating agency's performance measures, for all CMS assurances are reviewed and addressed if applicable.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other**

	Specify:

Performance Measure:
Meetings are held with the operating agency to discuss specific waiver issues (i.e., review of aggregated reports).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS/DDSN Agendas

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = Describe Group:
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Periodically/ as warranted	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify:

	Periodically/ as warranted

Performance Measure:
Policy changes are discussed with and/or communicated to the operating agency in a timely manner.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Memo

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☐ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☑ **Other** Specify: As warranted	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify: [ ]	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As warranted

If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
SCDHHS evaluates the CMS assurances through a QA process that allows various findings to be utilized in an efficient manner to identify and address areas of major concern, to identify the need for policy clarifications/amendments, remedial actions, and provider compliance. This allows the QA staff and QIO entity to perform focus reviews and develop trending reports to assure all participants are served fairly and equitably based on Medicaid policies and procedures. These methods also allow SCDHHS to regularly discuss and analyze the results of all findings/collected data to ensure participants' outcomes and experiences are continuously beneficial.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The SCDHHS QIO produces monthly and quarterly reports of findings based on level of care validation reviews. These reports are shared with the operating agency, which is responsible for addressing all identified issues through a remediation plan, which may include training, policy corrections, or financial adjustments for Federal Financial Participation (FFP).

The SCDHHS QA staff produces a report of findings, which is also shared with SCDDSN. The report of findings discusses issues such as untimely level of care re-evaluations, incomplete service plans, and/or incorrect billings to Medicaid. SCDDSN is responsible for developing and implementing remedial actions to prevent future occurrences of the same issues.

Additionally, the SCDHHS QA staff produces a report card evaluation of the MOA and Service Contract. These evaluations are shared with SCDDSN on a quarterly basis. This evaluation monitors SCDDSN's compliance with agreed-upon terms, policies and procedures, etc., outlined in the MOA and Service Contract. Accordingly, SCDDSN is responsible for taking remedial actions(s) as necessary to become in compliance within a timely manner.

All identified issues and plans of remediation are kept in a master file by the SCDHHS QA staff to consistently evaluate the quality improvement initiatives of the operating agency.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ Aged or Disabled, or Both - General					
	☑	Aged	65	65	☐
	☑	Disabled (Physical)	0	64	
	☑	Disabled (Other)	0	64	
○ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○ Mental Retardation or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

Participants must be enrolled prior to age 65 but will remain eligible for Waiver services after their 65th birthday if all other eligibility factors continue to be met. Waiver services are limited to participants with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive, degenerative illness, disease, dementia, or a neurological disorder related to aging, regardless of the age of onset. Where the individual:

1. Has urgent circumstances affecting his/her health or functional status; and,
2. Is dependent on others to provide or assist with critical health needs, basic activities of daily living or requires daily monitoring or supervision in order to avoid institutionalization; and,
3. Needs services not otherwise available within existing community resources, including family, private means and other agencies/programs, or for whom current resources are inadequate to meet the basic needs of the individual, which would allow them to remain in the community.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Participants on the HASCI Waiver before age 65 remain eligible for Waiver services after their 65th birthday if all other eligibility factors continue to be met.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  [ ]

  The cost limit specified by the State is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount: [ ]

    The dollar amount *(select one)*

- **Is adjusted each year that the waiver is in effect by applying the following formula:**

  Specify the formula:

- **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- **The participant is referred to another waiver that can accommodate the individual's needs.**
- **Additional services in excess of the individual cost limit may be authorized.**

  Specify the procedures for authorizing additional services, including the amount that may be authorized:

- **Other safeguard(s)**

  Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who

are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	788
Year 2	842
Year 3	892
Year 4 (renewal only)	945
Year 5 (renewal only)	998

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	700
Year 2	750
Year 3	800
Year 4 (renewal only)	850
Year 5 (renewal only)	900

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This**

schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

This Waiver maintains two waiting lists based on level of need: an Urgent and a Regular waiting list. The criteria for the Urgent waiting list are:

1. Very severe injury with functional limitations a spinal cord injury at the quadriplegic level or extremely or severe head injury.

2. Emergency need for assistance with personal care.

3. The recent loss (permanently gone within the past 90 days) or imminent risk of losing a primary caregiver (permanently gone within the next 90 days), and no other natural supports to replace the primary caregiver.

4. Recently discharged (within the past 90 days) or pending discharge (within the next 90 days) from acute care or rehabilitation hospital with complex unmet service needs.

5. Lack of active support network

Participants must have at least two of the above criteria in order to meet the requirements for inclusion on the Urgent waiting list. Participants who meet Urgent criteria will be allocated the first available HASCI Waiver slot. If more than one individual is on the Urgent waiting list, they will be allocated an available HASCI Waiver slot based on the earliest date of request. Individuals on the Regular waiting list will be allocated an available HASCI Waiver slot based on earliest date of request if there are no current applicants on the Urgent waiting list.

An individual terminated from the Waiver because of hospitalization or temporary admission to a nursing facility exceeding a full calendar month will have his or her Waiver slot held up to 90 calendar days if it is anticipated the individual will be discharged during that time. Re-enrollment in the Waiver is contingent upon the individual continuing to meet all eligibility requirements.

An individual terminated from the Waiver due to the interruption of Medicaid eligibility for more than 30 days but less than 90 calendar days will have his/her slot held up to 90 days for Medicaid eligibility to be reinstated.

An individual who has not received a Waiver service for 30 calendar days due to non-availability of a provider will have his or her slot held up to 90 calendar days. If a provider is located within 90 calendar days, the individual will be re-enrolled into the HASCI Waiver as long as all other eligibility criteria are met.

An individual who has resided in a nursing facility, hospital swing bed, or administrative day bed for 90 days or more and who requests to be discharged to receive community based services will immediately be allocated a Waiver slot after medical, financial and other Waiver eligibility requirements are met. Transition must be arranged through a DDSN Service Coordinator.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (•) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - (•) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

  Specify percentage: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902 (a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [x] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- **A special income level equal to:**

  Select one:

  - **300% of the SSI Federal Benefit Rate (FBR)**
  - **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

    Specify percentage:
  - **A dollar amount which is lower than 300%.**

    Specify dollar amount:
- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

  Select one:

  - **100% of FPL**
  - **% of FPL, which is lower than 100%.**

    Specify percentage amount:
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- (●) **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - (●) **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ( ) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ( ) **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

ii. Allowance for the spouse only (*select one*):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (*select one*):

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:
- **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  Specify:

  1. Prescription drugs above the four (4) prescriptions-per-month limit, not to exceed $54.00 per additional prescription per month.

  2. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity of eyeglasses.

  3. Dentures. A one-time expense not to exceed $651.00 per plate or $1320.00 for one full pair of dentures. A licensed dental practitioner must certify necessity. An expense for more than one pair of dentures must be prior approved by State DHHS.

  4. Denture repair. Justified as necessary by a licensed dental practitioner. Not to exceed $69 per visit.

  5. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69 per visit.

6. Hearing Aids. A one-time expense. Not to exceed $1000.00 for one or $2000.00 for both. Necessity must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by State DHHS.

7. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage: [ ]
- ○ **The following dollar amount:**

  Specify dollar amount: [ ] If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

  [ ]
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- **The provision of waiver services at least monthly**
- **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

  Specify the entity:

- **Other**
  Specify:

  This Waiver employs both the Nursing Facility and ICF/MR levels of care in assessing potential Waiver eligibility. The majority of the participants currently enrolled in this Waiver are assessed using the Nursing Facility level of care. The initial Nursing Facility level of care evaluation is performed directly by the Medicaid agency. All reevaluations of the Nursing Facility level of care are done by service coordinators employed by contracted providers of the operating agency. All initial ICF/MR level of care evaluations are preformed directly by the operating agency, reevaluations of the ICF/MR level of care are preformed by service coordinators employed by contracted providers of the operating agency.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurse licensed by the State or Licensed Practical Nurse working under the auspices of a Registered Nurse. Physician (M.D. or D.O.) and the DDSN Director of Consumer Assessment. DDSN Director of Consumer Assessments: Minimum qualifications are a Master's degree in Social Work or a related field from an accredited college or university; or a Bachelor's degree in Social Work from an accredited college or university; or a Bachelor's degree from an accredited college or university in an unrelated field of study, and at least one year of experience in programs for persons with mental retardation or a service coordination program. Psychologist: Minimum qualifications are a Master's degree in psychology plus two years of experience working with persons with lifelong disabilities, or a Master's degree in a health or human service field plus four years experience working with person with lifelong disabilities.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

A standardized instrument is utilized to gather assessment information necessary for level of care determinations.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The same process is used. The same level of care instrument and process are used.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- **Every three months**

- **Every six months**
- **Every twelve months**
- **Other schedule**
  Specify the other schedule:

  At least every 365 days from the date of the previous LOC determination.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- **The qualifications are different.**
  Specify the qualifications:

  Service Coordinators must hold a Master's or Bachelor's degree in Social Work or a related field or a Bachelor's degree in an unrelated field of study and have one (1) year of experience working with individuals with head and spinal cord injury or related disabilities, or in a case management program.

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

An automated tickler system produced by the Medicaid agency tracks due dates and timing of reevaluations if the Medicaid agency has not received level of care determinations in a timely manner inquires and requests are sent for the outstanding level of cares. Additionally if any level of care is found out of date FFP is taken back from the operating agency for any services that were billed when the level of care was not timely.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The State assures that documentation of all level of care evaluations and reevaluations are maintained for a minimum of 3 years. These records are maintained in the individual case record with the service coordination provider.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Proportion of new enrollees whose Level of Care completion predates waiver enrollment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Waiver Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Enrollment Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of participants whose Level of Care reevaluation does not occur prior to the 365th day of the previous Level of Care evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Tracking System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN CAT log

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):

Other
If 'Other' is selected, specify:
DDSN QIO Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☑ **Other** Specify: Delmarva	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of new enrollees whose initial Level of Care was conducted using correct instruments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS QIO Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**

☑ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of participants whose Level of Care outcome was appropriately determined.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS QIO Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative**

		Sample Confidence Interval = =/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS QIO reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**

☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DDSN Operations staff will address waiver problems when discovered. A log of participant specific problems and dates of corrective actions will be maintained and provided to the administrative agency at least quarterly.

Additionally, when individual problems may be discovered, providers must submit a plan that describes the actions taken to correct the problem. Follow-up reviews are conducted to assure corrections are made.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Long-term care options are discussed with potentially eligible individuals (or their legal representatives) during the assessment and subsequent visits.

A written Freedom of Choice Form (Service Choice Form) is secured from each Waiver participant to ensure that the participant is involved in planning his/her long-term care. This choice will remain in effect until the participant changes his/her mind. If the participant lacks the physical or mental ability required to make a written choice regarding his/her care, a responsible party may sign the Freedom of Choice Form.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Participant Service Choice Forms are maintained for a minimum three years with the contracted providers of the operating agency. The Freedom of Choice Form is maintained in the participant's record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The operating agency requires that each provider agency be in compliance with Title VI and establish a grievance procedure to assure that everyone is given a fair and timely review of all complaints alleging discrimination. All contracts through the operating agency with provider agencies will contain an "Assurance of Compliance" statement. Compliance Coordinators within the provider agencies will be responsible for assuring compliance and access to services by persons with limited English proficiency. The Compliance Coordinator is responsible for maintaining records documenting the complaints filed and actions that are taken to bring resolution to the complaint(s). A State Compliance Coordinator will be responsible for monitoring the compliance process. The State Coordinator will assist the provider agency Compliance Coordinator with identifying resources when necessary. The State Compliance Coordinator will notify the administrative agency of any discrimination complaints that have been filed.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Attendant Care/Personal Assistance Services
Statutory Service	Day Habilitation
Statutory Service	Prevocational Services
Statutory Service	Residential Habilitation

Statutory Service	**Respite Care Services**
Statutory Service	**Supported Employment Services**
Extended State Plan Service	**Occupational Therapy**
Extended State Plan Service	**Physical Therapy**
Extended State Plan Service	**Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.**
Extended State Plan Service	**Speech, hearing and language services**
Other Service	**Behavioral Support Services**
Other Service	**Environmental Modifications**
Other Service	**Health Education for Consumer-Directed Care**
Other Service	**Medicaid Waiver Nursing**
Other Service	**Medical Supplies, Equipment and Assistive Technology**
Other Service	**Peer Guidance for Consumer-Directed Care**
Other Service	**Personal Emergency Response Systems**
Other Service	**Private Vehicle Modifications**
Other Service	**Psychological Services**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care/Personal Assistance Services

Service Definition *(Scope):*

Attendant Care/Personal Assistance Services are supports for personal care and activities of daily living specific to the assessed needs of a medically stable individual with physical and/or cognitive impairments. Supports may include direct care, hands-on assistance, direction and/or cueing, supervision, and nursing to the extent permitted by State law. Supports may be provided in the participant's home and/or a variety of community settings as indicated in the Support Plan, but only when attendant care/personal assistance is not already available in such settings. Housekeeping activities incidental to care or essential to the health and welfare of the participant, rather than the participant's family, may be provided as specified in the Support Plan. Supports provided during community access activities must directly relate to the participant's needs for care and/or supervision. Transportation may be provided as a component of Attendant Care/Personal Assistance Services when necessary for provision of personal care or performance of daily living activities. Cost of incidental transportation is included in the rate paid to providers.

Supervision will be provided by a nurse licensed to practice in the state. The frequency and intensity of the supervision will be specified in the participant's Support Plan.

As an option, supervision may be performed directly by the participant or a responsible party, when the participant or responsible party has been trained to perform this function, and when safety and efficacy of supervision provided by the participant or responsible party has been certified by a licensed nurse or otherwise as provided in State law. Certification must be based on direct observation of the participant or responsible party and the specific attendant care/personal assistance provider(s) during actual provision of care. Documentation of this certification will be maintained in the participant's Support Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The proposed limits on the amount, duration or frequency for the service are consistent with assuring health and welfare based on survey input from HASCI Waiver participants, and a utilization analysis report. The SCDDSN analysis report estimates a total of 178 participants who may be affected by the proposed waiver service limits at a cost savings of

$667,193. The new proposed limit is 49 hours per week, which will be authorized on a weekly basis. The weekly authorization will allow a participant to schedule services with more flexibility to best meet their needs, coordinate available community supports, natural supports, and other resources. The current HASCI Waiver allows up to 10 hours per day of Attendant Care/Personal Assistance to be authorized on a short-term basis (not to exceed 90 days)due to special need circumstances. This safety net is unchanged in the proposed HASCI Waiver Amendment. Additionally, the HASCI Waiver will continue to offer options for hourly, daily, and institutional Respite Care to provide relief to caregivers, as well as, services for individuals who live alone or are alone for any part of the day or night and would otherwise require extensive routine supervision. The Personal Emergency Response System (PERS) is a waiver service that enables an individual to secure help in an emergency situation while living independently and assuring their health care needs.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent attendant care providers
Agency	DSN Board/contracted providers
Agency	Attendant care provider agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care/Personal Assistance Services

Provider Category:
Individual

Provider Type:
Independent attendant care providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract Scope of Service/DDSN Home Supports Caregiver Policy, Pre-service Training Requirements andOrientation (567-01-DD) which lists requirements to include the outlineof minimum requirements for the curriculum for HASCI Waiver caregivers

Verification of Provider Qualifications

Entity Responsible for Verification:
Licensed nurse under a contract with state Medicaid agency

Frequency of Verification:
Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care/Personal Assistance Services

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDSN Home Supports Caregiver Policy, Pre-service Training Requirements andOrientation (567-01-DD) which lists requirements to include the outlineof minimum requirements for the curriculum for HASCI Waiver caregivers
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Attendant Care/Personal Assistance Services

Provider Category:
Agency
Provider Type:
Attendant care provider agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Contract scope of services
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Annually/biannually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Service Definition *(Scope):*

Day Habilitation is assistance with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the participant resides. Services shall normally be provided four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's Support Plan.

Day Habilitation services shall focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Support Plan. In addition, Day Habilitation services may reinforce skills taught in school, therapy or other settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Individual	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	DSN Board/contracted providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency

Provider Type:
Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Contracted with Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Individual

Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Contracted with Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Prevocational Services
Alternate Service Title (if any):

Service Definition *(Scope):*
Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

When compensated, individuals are paid less than 50 percent of the minimum wage. Activities include in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of service as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Individual	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	DSN Board/contracted providers
Agency	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Individual

Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency

Provider Type:
DSN Board/contracted providers

Provider Qualifications

License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency

Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Residential Habilitation

Alternate Service Title (if any):

Service Definition *(Scope):*
Residential Habilitation means personal care, assistance with activities of daily living, supervision, behavioral supports, and skills training provided in a licensed residential program or unlicensed setting. Individually tailored supports and training assist the participant to reside in the most integrated setting appropriate to his or her needs. Supports may include direct care, hands-on assistance, direction and/or cueing, supervision, and nursing to the extent permitted by State law. Training is focused on the acquisition, retention, or improvement in skills for living in the community with maximum independence. Supports may include social and leisure activities and community inclusion opportunities.

Payment for Residential Habilitation does not include the cost of room and board or building maintenance, upkeep and improvement, other than such costs for modifications or adaptations required to assure the health and safety of residents, or to meet requirements of the applicable life safety code. Payment for Residential Habilitation will not be made, directly or indirectly, to members of the participant's immediate family. Payment will not be made for the routine care and supervision expected to be provided by a family or residential provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider	Provider Type Title

Category	
Agency	Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Individual	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	DSN Board/contracted providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Individual
Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC).
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care Services

Service Definition *(Scope):*

Personal care and supervision provided to individuals unable to care for themselves. Respite Care is provided on a short-term basis because of the absence of or need for relief of regular unpaid caregivers. Respite Care services are provided in a variety of settings and may be provided on an hourly or daily basis. FFP will not be claimed for the cost of room and board except when provided as part of Respite Care provided in a facility approved by the State that is not a private residence.

Respite care may be provided in the following location(s):

· Individual's home or other private residence selected by the consumer/representative.
· Group home (may be defined as a DDSN residential facility, DSS foster care facility or CRCF)
· Foster home
· Medicaid certified hospital
· Medicaid certified nursing facility
· Medicaid certified ICF/MR
· Licensed Community Residential Care Facility (CRCF)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSN Board/contracted providers
Agency	Hospital
Agency	Residential Care Facility
Agency	Respite provider agencies
Agency	Nursing Facility
Agency	Medicaid certified ICF/MR
Agency	Foster Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Respite care standards policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outlineof minimum requirements for the curriculum for HASCI Waiver caregivers
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Agency
Provider Type:
Hospital
Provider Qualifications
License *(specify):*
Yes, SC Code, Sec. 44-7-260 Reg. #61-16, Equivalent for NC & GA
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Environmental Control; Medicaid agency
Frequency of Verification:
Upon Enrollment;Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Agency
Provider Type:
Residential Care Facility
Provider Qualifications

License *(specify):*
Yes, SC Code, Sec. 44-7-260 Reg. #61-84, Equivalent for NC & GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Environmental Control; Medicaid Agency
Frequency of Verification:
Upon Enrollment;Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Agency
Provider Type:
Respite provider agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
MOA and Service Contract with Department of Health and Human Services
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Upon Enrollment; Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Agency
Provider Type:
Nursing Facility
Provider Qualifications
License *(specify):*
Yes, SC Code, Sec. 44-7-250 Reg. #61-17, Equivalent for NC & GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Environmental Control and Medicaid agency
Frequency of Verification:
Upon Enrollment;Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Agency
Provider Type:
Medicaid certified ICF/MR
Provider Qualifications
License *(specify):*
Yes, SC Code, Sec. 44-7-250 Reg. #61-17
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Respite care standards policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outlineof minimum requirements for the curriculum for HASCI Waiver caregivers
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Environmental Control
Frequency of Verification:
Upon Enrollment; Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Agency
Provider Type:
Foster Home
Provider Qualifications
License *(specify):*
Yes, SC Code, Sec. 20-7-2250
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Social Services
Frequency of Verification:
Upon Enrollment;Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment Services

Service Definition *(Scope):*

Supported Employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals receiving Waiver services, including supervision and training. When Supported Employment services are provided at the work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment services furnished under the Waiver are not available under a program funded by the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation may be provided between the participant's residence and the site of habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Agency	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	DSN Board/contracted providers
Individual	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment Services

Provider Category:
Agency
Provider Type:
Rehabilitation programs certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by the Commission on the Accreditation of Rehabilitation Facilities (CARF)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment Services

Provider Category:
Agency
Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:

Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment Services

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment Services

Provider Category:
Individual
Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

Service Definition *(Scope):*

Services that are provided when occupational therapy services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from occupational therapy furnished under the State plan. The provider qualifications specified in the State plan apply.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Occupational Therapy Groups
Individual	Occupational Therapists

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Occupational Therapy Groups

Provider Qualifications

License *(specify):*

Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual

Provider Type:
Occupational Therapists

Provider Qualifications

License *(specify):*
Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid agency

Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Physical Therapy

Service Definition *(Scope):*
Services that are provided when physical therapy services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from physical therapy furnished under the State plan. The provider qualifications specified in the State plan apply.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Individual	**Physical Therapists**
Agency	**Physical Therapy Groups**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Individual
Provider Type:
Physical Therapists
Provider Qualifications
License *(specify):*
Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:
Physical Therapy Groups
Provider Qualifications
License *(specify):*
Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.

Service Definition *(Scope):*

Services that are provided when the limits of prescribed drugs under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from prescribed drug services furnished under the State plan. The provider qualifications specified in the State plan apply. An additional three (3) prescribed drugs over the State plan limit will be allowed under this waiver for individuals who are eligible.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Three additional prescription drugs above the state plan limit.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy Providers
Individual	Pharmacists

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.

Provider Category:

Agency

Provider Type:

Pharmacy Providers

Provider Qualifications

License *(specify):*

Pharmacy permit chapter 43 section 40-43-10 et.seq. SC code of laws. Equivalent in NC and GA

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.

Provider Category:
Individual
Provider Type:
Pharmacists
Provider Qualifications
License *(specify):*
Pharmacy permit chapter 43 section 40-43-10 et.seq. SC code of laws. Equivalent in NC and GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Speech, hearing and language services
Service Definition *(Scope):*
Services that are provided when speech, hearing and language services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from speech, hearing and language services furnished under the State plan. The provider qualifications specified in the State plan apply.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Speech Pathology Groups
Individual	Speech Pathologists
Agency	Audiology Groups
Agency	Speech Therapy Group
Individual	Speech Therapists
Individual	Audiologists

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, hearing and language services

Provider Category:
Agency
Provider Type:
Speech Pathology Groups
Provider Qualifications
License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing, and Regulation; Medicaid agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, hearing and language services

Provider Category:
Individual
Provider Type:
Speech Pathologists
Provider Qualifications
License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid agency
Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, hearing and language services

Provider Category:
Agency
Provider Type:
Audiology Groups
Provider Qualifications
License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing, and Regulation; Medicaid agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, hearing and language services

Provider Category:
Agency
Provider Type:
Speech Therapy Group
Provider Qualifications
License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA
Certificate *(specify):*
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing, and Regulation; Medicaid agency
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Speech, hearing and language services

Provider Category:
Individual

Provider Type:
Speech Therapists

Provider Qualifications

License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid agency

Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech, hearing and language services

Provider Category:
Individual

Provider Type:
Audiologists

Provider Qualifications

License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support Services
Service Definition *(Scope):*
Behavioral support services address problem behaviors of an individual by using validated practices to identify causes and appropriate interventions that prevent or reduce occurrence. Behavioral support services include functional behavior assessments and analyses; development of behavioral support plans; implementing interventions designated in behavioral support plans; training key persons to implement interventions designated in behavioral support plans; monitoring effectiveness of behavioral support plans and modifying as necessary; and educating family, friends, or service providers concerning strategies and techniques to assist the participant in controlling/modifying inappropriate behaviors.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSN Boards/contracted providers
Agency	Behavior support providers approved by SCDDSN/SCDHHS
Agency	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Individual	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)
Individual	Behavior Support providers approved by SCDDSN/SCDHHS

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Agency
Provider Type:
DSN Boards/contracted providers
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Agency
Provider Type:
Behavior support providers approved by SCDDSN/SCDHHS
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Agency
Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs /Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Individual

Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Agency

Provider Type:
Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs /Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services

Provider Category:
Individual

Provider Type:
Behavior Support providers approved by SCDDSN/SCDHHS

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs /Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Modifications

Service Definition *(Scope):*
Those physical adaptations to the home, required by the individual's Support Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home. The home must be a privately owned residence occupied by the participant. Modifications to publicly funded group homes or community residential facilities are not permitted. Such adaptations may include the installation of ramps and grab-bars, widening of doorways and automatic door systems, modification of bathroom or kitchen facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual, floor covering to facilitate wheelchair access, fencing necessary for a participant's safety. Environmental modifications may also include consultation and assessments to determine the specific needs and follow-up inspections upon completion of the project.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Environmental modifications will not be approved solely for the needs or convenience of other occupants of the home or care providers. Modifications that add to the total square footage of the home are available only when this modification proves to be the most cost effective solution. All services shall be provided in accordance with applicable state and local building codes and shall be subject to the state procurement act.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Environmental Modifications are subject to the guidelines established by DDSN and must be within a limit of $20,000 dollars per request.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors with a retail or wholesale business license contracted to provide services
Individual	Licensed Occupational and Physical Therapists
Agency	Licensed Occupational and Physical Therapist Agencies
Agency	Licensed Contractor
Agency	Technicians or professionals certified in the installation and repair of manufacturers equipment
Agency	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)
Individual	Licensed Contractors
Individual	Technicians or professionals certified in the installation and repair of manufacturers equipment
Individual	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)
Agency	DSN Boards/contracted providers
Agency	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)
Individual	Vendors with a retail or wholesale business license contracted to provide services
Agency	Durable Medicaid Equipment Providers
Individual	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
Vendors with a retail or wholesale business license contracted to provide services

Provider Qualifications

License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420

Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Licensed Occupational and Physical Therapists
Provider Qualifications
License *(specify):*
Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid agency
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency
Provider Type:
Licensed Occupational and Physical Therapist Agencies
Provider Qualifications
License *(specify):*
Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency
Provider Type:
Licensed Contractor
Provider Qualifications
License *(specify):*
Code of laws, 1976 as amended 40-59-15 et seq.
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
Technicians or professionals certified in the installation and repair of manufacturers equipment

Provider Qualifications

License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420

Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Rehabilitation Engineering Society of North America (RESNA)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization and/ or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
Licensed Contractors
Provider Qualifications
License *(specify):*
Code of laws, 1976 as amended 40-59-15 et seq.
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
Technicians or professionals certified in the installation and repair of manufacturers equipment
Provider Qualifications
License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization and/ or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:
Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Rehabilitation Engineering Society of North America (RESNA)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
DSN Boards/contracted providers

Provider Qualifications

License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by Professional Resources in Management (PRIME)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization and/ or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Vendors with a retail or wholesale business license contracted to provide services

Provider Qualifications

License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Agency

Provider Type:
Durable Medicaid Equipment Providers

Provider Qualifications

License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by Professional Resources in Management (PRIME)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization and/ or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Health Education for Consumer-Directed Care

Service Definition *(Scope):*
Health Education for Consumer Directed Care prepares and assists capable individuals who desire to manage their own personal care or family members who desire to manage the personal care of an individual not capable of self-management. It is instruction provided by a licensed registered nurse regarding the nature of their specific medical condition and the promotion of good health, and prevention/monitoring of secondary medical conditions. The nurse will utilize the "Key to Independence Manual" from the Shepherd Center in Atlanta, Georgia or a curriculum approved by DDSN as a guide in providing education on bladder and bowel care, skin care, respiratory care, sexuality, substance abuse issues, and monitoring of health status.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Agencies
Agency	DSN Board/contracted providers
Individual	Registered Nurses
Agency	Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) that employ/contract with registered nurses

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health Education for Consumer-Directed Care

Provider Category:
Agency
Provider Type:
Nursing Agencies
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*
Other Standard *(specify):*
Contract Scope of Service
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Annually/biannually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health Education for Consumer-Directed Care

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*
Other Standard *(specify):*

Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health Education for Consumer-Directed Care

Provider Category:
Individual

Provider Type:
Registered Nurses

Provider Qualifications

License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*
Contract scope of services

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid agency

Frequency of Verification:
Annually/biannually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health Education for Consumer-Directed Care

Provider Category:
Agency

Provider Type:
Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) that employ/contract with registered nurses

Provider Qualifications

License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*
Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF) that employ/contract with registered nurses

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:

Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medicaid Waiver Nursing

Service Definition *(Scope):*

Services specified in the plan of service which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Medicaid Waiver Nursing is limited to either 60 hours per week of LPN or 45 hours per week of RN. If a combination of LPN and RN is used, the combined hours per week cannot exceed the equivalent cost of either 60 hours per week of LPN or 45 hours per week of RN. If HASCI Waiver Nursing is combined with Attendant Care/Personal Assistance Services, the combined services, whether routine or short term, shall not exceed 10 hours per day.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Agencies
Individual	Registered Nurses

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medicaid Waiver Nursing

Provider Category:

Agency

Provider Type:

Nursing Agencies

Provider Qualifications

License *(specify):*

Yes, Code of laws 40-33-10 et seq

Certificate *(specify):*

Other Standard *(specify):*
Contract Scope of services

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Upon Enrollment Annually/Biannually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medicaid Waiver Nursing

Provider Category:
Individual

Provider Type:
Registered Nurses

Provider Qualifications

License *(specify):*
Yes, Code of laws 40-33-10 et seq

Certificate *(specify):*

Other Standard *(specify):*
Contract Scope of services

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Upon Enrollment Annually/Biannually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Medical Supplies, Equipment and Assistive Technology

Service Definition *(Scope):*
Specialized medical supplies and equipment to include devices, controls, or appliances specified in the participant's Support Plan which enable increased ability to perform activities of daily living, or to perceive, control, or communicate with the environment.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the state plan or which are not available under the state plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacturer, design and

installation. Cost of items may include consultation and assessments to determine the specific needs, follow-up inspection after items are received, training in use of equipment/assistive technology, repairs not covered by warranty, and replacement of parts or equipment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors with a retail or wholesale business license
Agency	Licensed Occupational or Physical Therapy Agencies
Agency	Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by RESNA
Individual	Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)
Agency	Durable Medical Equipment providers
Individual	Technicians or professionals certified in the installation and repair of manufacturer's equipment
Individual	Vendors with a retail or wholesale business license
Individual	Licensed Occupational or Physical Therapists
Individual	Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by RESNA
Agency	Technicians or professionals certified in the installation and repair of manufacturer's equipment
Agency	DSN Board/contracted providers
Agency	Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:

Agency

Provider Type:

Vendors with a retail or wholesale business license

Provider Qualifications

License *(specify):*

Yes, Section 33-1-200 et. Seq. thru 33-1-420

Certificate *(specify):*

Other Standard *(specify):*

Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Agency

Provider Type:
Licensed Occupational or Physical Therapy Agencies

Provider Qualifications

License *(specify):*
Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Agency

Provider Type:
Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by RESNA

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Rehabilitation Engineering Society of North America. (Individuals and Agencies)

Other Standard *(specify):*
Department of Disabilities and Special Needs/Medicaid agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Individual

Provider Type:
Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by Professional Resources in Management (PRIME)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Agency

Provider Type:
Durable Medical Equipment providers

Provider Qualifications

License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Individual
Provider Type:
Technicians or professionals certified in the installation and repair of manufacturer's equipment
Provider Qualifications
License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Individual
Provider Type:
Vendors with a retail or wholesale business license
Provider Qualifications
License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Individual
Provider Type:
Licensed Occupational or Physical Therapists
Provider Qualifications
License *(specify):*
Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Individual

Provider Type:
Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by RESNA

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Rehabilitation Engineering Society of North America (RESNA)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Agency

Provider Type:
Technicians or professionals certified in the installation and repair of manufacturer’s equipment

Provider Qualifications

License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420

Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Supplies, Equipment and Assistive Technology

Provider Category:
Agency
Provider Type:
Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)
Provider Qualifications
License *(specify):*
)
Certificate *(specify):*
Certified by Professional Resources in Management (PRIME)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Guidance for Consumer-Directed Care

Service Definition *(Scope):*

Peer Guidance for Consumer Directed Care prepares and assists capable individuals who desire to manage their own personal care. It is information, advice, and encouragement provided by a trained Peer Mentor to help a person with spinal cord injury/severe physical disability in recruiting, training, and supervising primary and back-up attendant care providers. The Peer Mentor is a person with a spinal cord injury/severe physical disability who successfully lives in the community with a high degree of independence and who directs his/her personal care. The Peer Mentor serves as a role model and shares information and advice from his/her own experiences. The Peer Mentor will use the "Peer Support Curriculum" from the Shepherd Center in Atlanta, Georgia or other curriculum approved by DDSN.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSN Board/contracted providers
Individual	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)
Agency	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Guidance for Consumer-Directed Care

Provider Category:

Agency

Provider Type:

DSN Board/contracted providers

Provider Qualifications

License *(specify):*

Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Guidance for Consumer-Directed Care

Provider Category:
Individual

Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Guidance for Consumer-Directed Care

Provider Category:
Agency

Provider Type:
Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/ Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Guidance for Consumer-Directed Care

Provider Category:
Agency
Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Emergency Response Systems
Service Definition *(Scope):*
PERS is an electronic device which enables individuals at high risk of institutionalization to secure help in an emergency. The participant may wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for any part of the day or night, and who would otherwise require extensive routine supervision.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response providers
Agency	DSN Boards/contracted providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Agency
Provider Type:
Personal Emergency Response providers
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
1. FCC Part 68
2. UL (Underwriters Laboratories) approved as a "health care signaling product."
3. The product is registered with the FDA as a medical device under the classification "powered environments control signaling product."

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Agency
Provider Type:
DSN Boards/contracted providers
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
1. FCC Part 68

2. UL (Underwriters Laboratories) approved as a "health care signaling product."
3. The product is registered with the FDA as a medical device under the classification "powered environments control signaling product."

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Private Vehicle Modifications

Service Definition *(Scope):*
Modifications to a privately owned vehicle to be driven by or routinely used to transport the participant. May include any equipment necessary to make the vehicle accessible to the participant. Modifications of a vehicle owned by a publicly funded agency are not permitted. Private vehicle modifications include consultation and assessment to determine the specific modifications/equipment needed, follow-up inspection after modifications are completed, training in use of equipment, repairs not covered by warranty, and replacement of parts or equipment. The approval process for private vehicle modifications is initiated based upon the needs specified in the participant's Support Plan and following confirmation of the availability of a privately owned vehicle to be driven by or routinely used to transport the participant. The approval process is the same for any private vehicle modification, regardless of ownership. Each request must receive prior approval following programmatic and fiscal review and shall be subject to the state procurement act. Programmatic approval alone may be given for emergency repair of equipment to ensure safety of the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Private Vehicle Modifications are subject to the guidelines established by DDSN and must be within the limit of $30,000 per request.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME providers
Agency	Occupational Therapy Agencies or Physical Therapy Agencies

Individual	**Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)**
Agency	**Technicians or professionals who are certified in the installation and repair of manufacturer's equipment**
Agency	**Vendor with a retail or wholesale business license contracted to provide services**
Individual	**Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)**
Individual	**Licensed Occupational Therapists or Physical Therapists**
Agency	**DSN Board/contracted providers**
Individual	**Technicians or professionals who are certified in the installation and repair of manufacturer's equipment**
Agency	**Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)**
Individual	**Vendor with a retail or wholesale business license contracted to provide services**
Agency	**Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Agency
Provider Type:
DME providers
Provider Qualifications
License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Agency
Provider Type:
Occupational Therapy Agencies or Physical Therapy Agencies
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*

Other Standard *(specify):*

Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:

Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:

Individual

Provider Type:

Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Rehabilitation Engineering Society of North America (RESNA)

Other Standard *(specify):*

Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:

Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:

Agency

Provider Type:

Technicians or professionals who are certified in the installation and repair of manufacturer's equipment

Provider Qualifications

License *(specify):*

Yes, Section 33-1-200 et. Seq. thru 33-1-420

Certificate *(specify):*

Other Standard *(specify):*

Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:

Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Agency
Provider Type:
Vendor with a retail or wholesale business license contracted to provide services
Provider Qualifications
License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Individual
Provider Type:
Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by Professional Resources in Management (PRIME)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:

Individual

Provider Type:
Licensed Occupational Therapists or Physical Therapists
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Individual
Provider Type:
Technicians or professionals who are certified in the installation and repair of manufacturer's equipment
Provider Qualifications
License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Agency

Provider Type:
Rehabilitation Engineering Technologists, Assistive Technology Practitioners, and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Rehabilitation Engineering Society of North America (RESNA)

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Individual

Provider Type:
Vendor with a retail or wholesale business license contracted to provide services

Provider Qualifications

License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420

Certificate *(specify):*

Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Private Vehicle Modifications

Provider Category:
Agency
Provider Type:
Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by Professional Resources in Management (PRIME)
Other Standard *(specify):*
Contracted with Department of Disabilities and Special Needs/Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or Medicaid enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Psychological Services
Service Definition *(Scope):*
Psychological services address affective, cognitive, and substance abuse problems of an individual. Psychological services include psychiatric, neuropsychological, and psychological assessment and testing; development of treatment plans; individual/client specific family counseling regarding emotions, behavior or social interaction; cognitive rehabilitation therapy; alcohol/substance abuse counseling; and consultation with family members, friends and service providers to assist the participant with affective, cognitive and substance abuse problems.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Psychological service providers approved by SCDDSN/SCDHHS
Agency	Psychological service providers approved by SCDDSN/SCDHHS
Agency	DSN Boards/contracted providers
Individual	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Agency	Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)
Agency	Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Services

Provider Category:
Individual
Provider Type:
Psychological service providers approved by SCDDSN/SCDHHS
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
South Carolina Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Services

Provider Category:
Agency
Provider Type:
Psychological service providers approved by SCDDSN/SCDHHS
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
South Carolina Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Services

Provider Category:
Agency

Provider Type:
DSN Boards/contracted providers

Provider Qualifications

License *(specify):*
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
South Carolina Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Services

Provider Category:
Individual

Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)

Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:
South Carolina Department of Disabilities and Special Needs/Medicaid agency

Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Services

Provider Category:
Agency
Provider Type:
Rehabilitation programs certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF)
Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
South Carolina Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychological Services

Provider Category:
Agency
Provider Type:
Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified by the Commission on Rehabilitation Counselor Certification (CRCC)
Other Standard *(specify):*
Scope of Service verified by DDSN and approved by DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
South Carolina Department of Disabilities and Special Needs/Medicaid agency
Frequency of Verification:
Upon enrollment or service authorization and/or enrollment with Medicaid Agency

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Service Coordination is provided by the Department of Disabilities and Special Needs (DDSN) through contracts with:

1. The local Disabilities and Special Needs (DSN) Board providers.
2. Private providers and other approved/qualified providers.

Service Coordination staff prepares and monitor implementation of the Support Plan, assess service needs, facilitate initial Waiver enrollment, complete reevaluations for NF and ICF/MR levels of care, and monitor the health and welfare of the participants in the Head and Spinal Cord Injury Waiver.

SCDDSN will assist an individual in identifying alternate services and supports, if the HASCI Waiver cannot meet his or her needs. Service coordinators are currently discussing the HASCI Waiver amendment changes with participants and revising service plans as needed to address participant's assessed needs, including health and safety factors while promoting maximum independence of participants.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Community Residential Care Facilities, Home Health Agencies, Adult Day Health Care agencies, Personal Care Agencies and Attendants and DDSN are all required to have background checks done on direct care staff.

These are state level investigations performed by South Carolina Law Enforcement (SLED checks) for each of the agencies above that hire and recruit direct care staff. The State Health Department performs licensure inspections on CRCF and Home Health agencies. DDSN performs licensure inspections on its facilities. DDSN also conducts quality reviews of HASCI Waiver requirements.

Background checks are required for attendants providing attendant care/personal assistance services. DHHS reviews agency and independently enrolled attendant care/personal assistance providers to ensure background checks have been

performed on direct care staff. DDSN contracts with a provider of quality assurance and quality performance that conducts reviews of local Disabilities and Special Needs Boards at least annually. The quality contractor reviews a percentage of the personnel records of direct support staff (attendant care/personal assistance services staff) to determine if the minimum requirements for employment were met. The findings from the administrative reviews are shared with DDSN and with the State (DHHS).

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- (○) **No. The State does not conduct abuse registry screening.**
- ( ) **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ( ) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- (○) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type
Supervised Living Placement I (SLP I)
Supervised Living Placement II (SLP II)
Community Training Home II (CTH II)
Community Training Home I (CTH I)
Community Residential Care Facility -DDSN Contracted (CRCF)

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The individual is able to access community services on an on-going basis to increase his/her independence. The Waiver can provide supplemental services for persons that require more care and assistance than what is provided in that setting. Waiver services must comply with any licensing requirements of that setting.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supervised Living Placement I (SLP I)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Health Education for Consumer-Directed Care	☐
Private Vehicle Modifications	☐
Physical Therapy	☐
Peer Guidance for Consumer-Directed Care	☐
Residential Habilitation	☑
Psychological Services	☐
Attendant Care/Personal Assistance Services	☐
Occupational Therapy	☐
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	☐
Medicaid Waiver Nursing	☐
Respite Care Services	☐
Environmental Modifications	☐
Behavioral Support Services	☐
Prevocational Services	☐
Supported Employment Services	☐
Speech, hearing and language services	☐
Personal Emergency Response Systems	☐
Day Habilitation	☐
Medical Supplies, Equipment and Assistive Technology	☐

Facility Capacity Limit:

3

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑

Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Supervised Living Placement II (SLP II)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Health Education for Consumer-Directed Care	☐
Private Vehicle Modifications	☐
Physical Therapy	☐
Peer Guidance for Consumer-Directed Care	☐
Residential Habilitation	☑
Psychological Services	☐
Attendant Care/Personal Assistance Services	☐
Occupational Therapy	☐
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	☐
Medicaid Waiver Nursing	☐
Respite Care Services	☐
Environmental Modifications	☐
Behavioral Support Services	☐
Prevocational Services	☐
Supported Employment Services	☐
Speech, hearing and language services	☐
Personal Emergency Response Systems	☐
Day Habilitation	

	☐
Medical Supplies, Equipment and Assistive Technology	☐

Facility Capacity Limit:

3

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Training Home II (CTH II)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Health Education for Consumer-Directed Care	☐
Private Vehicle Modifications	☐
Physical Therapy	☐

Peer Guidance for Consumer-Directed Care	☐
Residential Habilitation	☑
Psychological Services	☐
Attendant Care/Personal Assistance Services	☐
Occupational Therapy	☐
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	☐
Medicaid Waiver Nursing	☐
Respite Care Services	☐
Environmental Modifications	☐
Behavioral Support Services	☐
Prevocational Services	☐
Supported Employment Services	☐
Speech, hearing and language services	☐
Personal Emergency Response Systems	☐
Day Habilitation	☐
Medical Supplies, Equipment and Assistive Technology	☐

Facility Capacity Limit:

4

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not

included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Training Home I (CTH I)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Health Education for Consumer-Directed Care	☐
Private Vehicle Modifications	☐
Physical Therapy	☐
Peer Guidance for Consumer-Directed Care	☐
Residential Habilitation	☑
Psychological Services	☐
Attendant Care/Personal Assistance Services	☐
Occupational Therapy	☐
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	☐
Medicaid Waiver Nursing	☐
Respite Care Services	☐
Environmental Modifications	☐
Behavioral Support Services	☐
Prevocational Services	☐
Supported Employment Services	☐
Speech, hearing and language services	☐
Personal Emergency Response Systems	☐
Day Habilitation	☐
Medical Supplies, Equipment and Assistive Technology	☐

Facility Capacity Limit:

2

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Residential Care Facility -DDSN Contracted (CRCF)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Health Education for Consumer-Directed Care	☐
Private Vehicle Modifications	☐
Physical Therapy	☐
Peer Guidance for Consumer-Directed Care	☐
Residential Habilitation	☑
Psychological Services	☐
Attendant Care/Personal Assistance Services	☐
Occupational Therapy	☐
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	☐
Medicaid Waiver Nursing	☐
Respite Care Services	

	☑
Environmental Modifications	☐
Behavioral Support Services	☐
Prevocational Services	☐
Supported Employment Services	☐
Speech, hearing and language services	☐
Personal Emergency Response Systems	☐
Day Habilitation	☐
Medical Supplies, Equipment and Assistive Technology	☐

Facility Capacity Limit:

N/A

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any

person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

Reimbursement for HASCI Waiver services may be made to certain family members who meet South Carolina Medicaid provider qualifications. The following family members may not be reimbursed: the spouse of a Medicaid participant; a parent of a minor Medicaid participant; a step-parent of a minor Medicaid participant; a foster parent of a minor Medicaid participant; any other person legally responsible (sole, joint or otherwise) for the Medicaid participant; and a court appointed guardian of a Medicaid participant. A family member that is a primary caregiver will not be reimbursed for Respite Care services. All other qualified family members may be reimbursed for their provision of the services listed above. Should there be any question as to whether a paid caregiver falls in any of the categories listed above, SCDHHS legal counsel will make a determination.

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Potential providers are given the opportunity to enroll/contract with South Carolina Medicaid and/or subcontract with DDSN. Potential providers are made aware of the requirements for enrollment through either the operating or administrating agency by contacting them directly. All potential providers are given a packet of information upon contacting the agencies that describe the requirements for enrolment, the procedures used to qualify and the timeframes established for qualifying and enrolling providers. Additionally, potential providers can find information regarding enrollment requirements and timeframes for enrollment at the state's website at: http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/BureauofLongTermCareServices/BECOMINGAcltcPROVIDER.asp, and at the operating agencies website of http://www.state.sc.us/ddsn/qpl/HowToBecomeQualified.htm . DDSN/DHHS will validate the provider meets all standards and qualifications and then the Medicaid agency may enroll the provider should they choose to enroll with the Medicaid agency.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of providers that meet required licensing, certification, and other state standards/enrollment criteria prior to the provision of Waiver services by provider type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN Provider Enrollments

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of waiver providers that continue to meet required licensing, certification and other state standards/enrollment criteria.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of non-licensed/non-certified providers that meet waiver requirements and other state standards.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Review

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):

Other
If 'Other' is selected, specify:
DHHS Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of providers, by provider type, that meet training requirements in the Waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Provider Enrollment

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence

		Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
a. A list of agencies applying to provide waiver services, reasons for denial, and steps that should be taken to reapply will be maintained.
b. Lists of agencies that were reviewed, compliance issues uncovered, and corrections made will be maintained along with correction and timeframes of correction.

DDSN will provide both lists to the administering agency on a quarterly basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Support Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☐ **Social Worker.**

  Specify qualifications:

- ☑ **Other**

  Specify the individuals and their qualifications:

  Service Coordinator (qualifications specified in Appendix C-3).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

  The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

During the planning process the participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant’s choosing provide input. The information obtained is used by the service coordinator in order to develop the Support Plan. The participant/legal guardian will receive a copy of the Support Plan upon completion. Copies will also be provided to other service providers of the participant’s/legal guardian’s choosing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Support Plan is developed by the Service Coordinator and is based on the comprehensive assessment of the Waiver participant's, needs, personal priorities (goals) and preferences. The participant, his/her legal guardian, caregivers, professional service providers and others of the participant's choosing provide input. A Support Plan is developed prior to the delivery of a Waiver funded service and at least annually thereafter.

Service Coordinators are informed of names and definitions of Waiver services that can be funded through the Waiver. The approved Waiver document is a part of the Waiver Manual used by Service Coordinators and any Waiver Amendment is made a part of the Waiver Manual and given to Service Coordinators.

Participation in the planning process (assessment, plan development, implementation) by the participant, his/her guardian, knowledgeable professionals and others of the participant's choosing, helps to assure that the participant's needs, personal goals/priorities and preferences are recognized and addressed by the Support Plan. All needs identified during the assessment process must be addressed. The Service Coordinator will utilize information about the participant's needs, personal goals and preferences to determine how those needs will be addressed. The Support Plan will include a statement of the participant's need, indication of whether or not the need relates to a personal goal/personal priority, the specific service to meet the need, the amount, frequency, duration of the service, and the type of provider who will furnish the service.

The Support Plan will include the roles and responsibilities of the Service Coordinator and the participant and his/her guardian for each service included in the plan. The Service Coordinator will have primarily responsibility for coordinating services but must rely on the participant /guardian to choose a service provider from among those available, avail him/herself for, and honor appointments scheduled with providers when needed for initial service implementation, and cooperate with coordination efforts. The degree of coordination may vary based on the needs of the participant and his/her support network and their preferences for self-coordination.

At a minimum, Service Coordinators will provide a quarterly contact with the service provider and/or family. On a quarterly basis, there will be a review of the entire Support Plan which includes a contact with the participant/participant's family. Changes to the Support Plan will be made as needed by the Service Coordinator when the results of monitoring or when information obtained from the participant, his/her guardian, and/or service providers indicates the need for a change to the Support Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Participants' needs, including potential risks associated with their situations, are assessed during the planning process and considered during plan development. The operating agency has a comprehensive assessment completed annually by the Service Coordinator prior to completing the participant's Support Plan, which assesses risks, including but not limited to, physical, financial, medical and developmental risks. Policies balancing risk and policies addressing interventions are utilized by Service Coordinators with the operating agency. The Service Coordinator assesses the participant's natural support network during completion of the annual comprehensive assessment. The Support Plan includes a section to be implemented during an emergency or natural disaster and a description for how care will be provided in the unexpected absence of a caregiver/supporter. The Service Coordinator is cued to assess the "back-up" plan during completion of the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants are given a list of providers of all waiver services in order to select a provider. This list includes phone numbers. Participants are encouraged to phone providers with questions, ask friends about their experiences with providers and utilize other information sources in order to select a provider.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Support Plan document and description of the planning process are approved by the Medicaid agency prior to implementation. Participant plans are available upon request. A sample of participant plans are reviewed by the operating agency and results shared with the Service Coordinator and his/her supervisor so that corrections can be made if needed. These results are also shared with DHHS. DHHS will also review a sample of plans on an annual basis.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

At least 365 days from the date of the previous service plan.

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Service Coordinator

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

At a minimum, Service Coordinators will provide quarterly contact with the Waiver participant and/or family. On a quarterly basis, there will be a review of the entire waiver Support Plan which includes the most recent contact with the participant's/family.

b. Monitoring Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of participants whose plans includes services and supports that are consistent with needs and personal goals identified in the comprehensive assessment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100%**

		Review
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of participants who received assessments in accordance with State policy.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Proportion of participants whose plans were completed in a timely fashion.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of participants who Plan of Supports was reassessed prior to the 365th day of the previous Plan of supports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO reports

Responsible Party for data collection/generation	**Frequency of data collection/generation**	**Sampling Approach***(check each that applies):*

(check each that applies):	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of participants who are receiving the services and supports as specified in their plans (i.e., type, amount, frequency, and duration).

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		+/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☑ **Annually**

Specify:	
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Reports regarding the unavailability of specific services and supports by area (i.e., region, board).

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider unavailability reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of participant records which contained an appropriately completed and signed Freedom of Choice form that specifies choice was offered between waiver services and institutional care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Proportion of Waiver participants who were offered choice among services and providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN QIO

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DDSN Operations staff will address waiver problems when discovered. A log of participant specific problems and dates of corrective actions will be maintained and provided to the SCDHHS at least quarterly.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The HASCI Waiver offers the participant an option to direct Attendant Care/Personal Assistance Services with employer authority. The participant or his/her Responsible Party (RP) can choose to direct the participant's care. The participant or RP must have no communication or cognitive deficits that would interfere with participant or RP direction.

Service Coordinators will provide detailed information to the Waiver participant and/or RP about participant direction as an option, including the benefits and responsibilities of the option. If the participant or RP want to pursue participant direction, additional information about the risks, responsibilities, and liabilities of the option will be shared by the Service Coordinator. Information about the role of the FMS is also provided and information concerning the hiring, management and firing of workers. Independent advocacy is available to recipients who feel the need for additional support.

Once the participant has chosen to direct his/her services, the Service Coordinator(s) will continue to monitor service delivery

and the status of the participant's health and safety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [x] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

1) CRCF
2) A Private residence
3) Temporary living arrangement such as
hotel/motel, shelter or camp

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

The participant or RP must have no communication or cognitive deficits that would interfere with participant or RP direction. The service coordinator will assess and determine if these criteria are met. Participants interested in self-directed care are prescreened to assure capability utilizing a standardized pre-screen form. If he/she is not capable a

responsible party may direct care if he/she passes the pre-screen. The prescreening form utilized is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction and assuring the health and welfare of the participant. The three principal areas screened during the assessment are communication, cognitive patterns, and mood and behavior patterns. The communication section assesses the ability of the participant/responsible party to make them understood and the ability of others to understand the participant/responsible party. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision making of the participant/responsible party. Finally the assessment tool reviews the mood and behavior patterns of the participant/responsible party to assess sad/anxious moods. The assessment is scored based on these three areas and the results are shared with the participant/responsible party. If the participant/responsible party disagrees with the results they may appeal the decision. The RN match visit is completed prior to service authorization.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time of the initial assessment, the Service Coordinator will introduce participant direction of Attendant Care/Personal Assistance services as an option and provide a brochure giving information about this option. The Service Coordinator will provide this information initially or at the request of the participant. If the participant is interested, the Service Coordinator will provide more details about the benefits and responsibilities of participant direction and determine continued interest. The Service Coordinator will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant direction. The Service Coordinator will continue to assess the participant’s interest on an annual basis or more frequently if requested by the participant.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant may choose to have waiver services directed by a representative and he/she may choose anyone (subject to DDSN or Medicaid Policy) willing to understand and assume the risks, rights and responsibilities of directing the participant’s care. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant’s preferences, and must agree to a predetermined frequency of contact with the participant. A representative may not be paid to be a representative, and may not be paid to provide waiver services to the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Attendant Care/Personal Assistance Services	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- ◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - ☑ **Governmental entities**
  - ☐ **Private entities**

- ○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- ○ **FMS are covered as the waiver service specified in Appendix C1/C3**

  The waiver service entitled:

- ◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The operating agency currently uses an FMS to provide these services to participants. This is a sole source procurement with a governmental entity.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment will occur to the FMS through an administrative grant from the operating agency. The payment does not come from the participant's budget.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [ ] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

The FMS will verify the participant's verification of the worker's minimum qualifications. UAP conducts all required background checks.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintains a separate account for each participant's participant-directed budget**
- [ ] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [ ] **Processes and pays invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

An annual independent audit is required to verify that expenditures are accounted for and disbursed according to General Accepted Accounting Practices.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or

authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Health Education for Consumer-Directed Care	☐
Private Vehicle Modifications	☐
Physical Therapy	☐
Peer Guidance for Consumer-Directed Care	☐
Residential Habilitation	☐
Psychological Services	☐
Attendant Care/Personal Assistance Services	☐
Occupational Therapy	☐
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	☐
Medicaid Waiver Nursing	☐
Respite Care Services	☐
Environmental Modifications	☐
Behavioral Support Services	☐
Prevocational Services	☐
Supported Employment Services	☐
Speech, hearing and language services	☐
Personal Emergency Response Systems	☐
Day Habilitation	☐
Medical Supplies, Equipment and Assistive Technology	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The FMS supports are provided by a sole source contractor, which is one of the operation agency's Disabilities and

Special Needs Boards. The operating agency will have a contract with the FMS to provide these supports. The supports include providing each participant with a checklist of responsibilities they have in hiring their workers, and verification of qualifications and requirements (this is accomplished jointly by UAP and the FMS). The operating agency will assess the performance of the FMS on a quarterly basis. The FMS is also required to have an independent financial audit every year.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- ○ **No. Arrangements have not been made for independent advocacy.**
- ◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Protection and Advocacy of South Carolina has agreed to provide this advocacy when requested. The Service Coordinator will provide their phone number and contact names to participants.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The Service Coordinator will accommodate the participant by providing a list of qualified providers they can select from to maintain service delivery. The Service Coordinator and the operating agency will work together to ensure the participant's health and safety in this transition and will work to avoid any break in service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the participant or his representative are no longer able to communicate or if they experience cognitive deficits which keep them from acting in their or the participant's best interest, the Service Coordinator will transition services from participant direction to agency directed services. The authorization of agency directed services will be coordinated by the Service Coordinator. The operating agency will use written criteria in making this determination. The participant and/or representative will be informed of the opportunity and means of requesting a fair hearing, choosing an alternate provider and the plan will be revised to accommodate changes.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for

the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	100	
Year 2	120	
Year 3	140	
Year 4 (renewal only)	160	
Year 5 (renewal only)	180	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The cost for background checks will be handled by UAP.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. **Participant Exercise of Budget Flexibility.** *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

An appeal may be made on behalf of a Waiver participant by a parent or legal guardian or the Waiver participant whenever any decision adversely affects his/her eligibility status and/or receipt of services. The Waiver participant or the parents/legal guardian of the Waiver participant is informed of this decision verbally and in writing when an adverse decision is made. The formal process of review and adjudication of actions/determinations is done under the authority of Section 1-23-310 et. seq., Code of Laws, State of South Carolina, 1976, as amended, and the Department of Health and Human Services regulations Section 126-150, et.seq.

A Waiver participant or the parent/legal guardian of a Waiver participant who is dissatisfied with a level of care decision by DDSN and/or DHHS has the right to request an appeal of the action, as well as the right to request an appeal of DDSN's decision to reduce, suspend, deny or terminate a waiver service. Waiver participants may also appeal any issues of choice of provider and choices of HCBS vs. institutional services.

A request for reconsideration of an adverse decision by DDSN must be sent in writing to the State Director at SCDDSN. A formal request for reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. In order for Waiver benefits/services to continue during the reconsideration/appeal process, the Waiver participant or the Waiver participant's parent/legal guardian's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

If the Waiver participant or the Waiver participant's parent/legal guardian continues to be dissatisfied with decision a request for appeal can be made to SCDHHS. The Waiver participant or the Waiver participant's parent/legal guardian must write a letter requesting an appeal within 30 days of the date of the official written notification issued by DDSN. If the appeal is filed within ten (10) days, services may continue pending the outcome of the hearing. If the adverse action is upheld, the Waiver participant or the Waiver participant's parent/legal guardian may be required to repay Waiver benefits received during the reconsideration/appeal process.

Information regarding the right to appeal and instructions for initiating an appeal are printed on the Notice of Suspension, Denial, Reduction and Termination Forms and the formal letter of denial from DDSN for eligibility. Also included on these forms is the information on continuation of services and possible liability if the participant elects to continue receiving services.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Department of Disabilities and Special Needs operates the Complaint/Grievance System.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Complaints are taken at the Department of Disabilities and Special Needs. A Waiver participant or the Waiver participant's parent/legal guardian are notified of their right to complain/grieve through a Participant's Rights and Responsibilities statement reviewed and signed at the initial visit during waiver entry. When a Waiver participant or the Waiver participant's parent/legal guardian elects to file a grievance or make a complaint, the Waiver participant or the Waiver participant's parent/legal guardian is informed that doing so is not a prerequisite or substitute for a Fair Hearing.

Each applicant for services or participant has the right to make complaints regarding services or treatment. Every effort will be made to resolve concerns as quickly as possible and at the most immediate staff level that can properly address the concern.

A three-step process is established to ensure a fair and impartial review of complaints. The written grievance/appeal will be made to the HASCI Division Director. The HASCI Division Director or designee shall investigate the concern. The HASCI Division Director shall issue a written decision within ten (10) working days of receipt of the written grievance/appeal. If the grievance/appeal is resolved, it shall be acknowledged in writing and documented in the consumer's record.

If the Waiver participant or the Waiver participant's parent/legal guardian is not satisfied, he/she may appeal in writing to the Associate State Director for Policy. The Associate State Director for Policy shall review the facts of the case and all supporting documents, consult with the HASCI Division, and render a written decision within ten (10) working days. If the grievance/appeal is resolved, it shall be acknowledged in writing and documented in the participant's record.

If the Waiver participant or the Waiver participant's parent/legal guardian is not satisfied with this decision, he/she may appeal in writing. All information regarding reconsiderations and appeals for the HASCI Waiver is in Appendix F-1 of this application.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The South Carolina Child Protection Reform Act as specified in Section 63-7-310, et seq, requires reporting of abuse, neglect and exploitation to those state agencies having statutory authority to receive reports and investigate allegations of suspected abuse, neglect or exploitation. The South Carolina Omnibus Adult Protection Act as specified in S.C. Code Ann. Section 43-35-5 (2006), et seq., Section 43-35-10, requires the reporting of suspected abuse, neglect, or exploitation of a vulnerable adult, age 18 and above. These agencies include Child Protective Services and Adult Protective Services - South Carolina Department of Social Services (DSS) and local and state law enforcement agencies (The appropriate reporting agency is determined by the age of the victim, suspected perpetrator, and the location of the alleged incident). These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing. These incidents are defined as physical abuse, emotional, mental or psychological abuse, verbal, threatened or sexual abuse, neglect, and physical and financial exploitation. Mandatory reporters have a duty to report if they have information, facts or evidence that would lead a reasonable person to believe that a child has been or is at risk for abuse, neglect or exploitation. Mandated reporters are defined as professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected abuse, neglect, or exploitation to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the abuse, neglect or exploitation.

The reporting of Critical Incidents (100-09-DD) must be followed. A critical incident is an “unusual, unfavorable occurrence that is: a) not consistent with routine operations; b) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and c) occurs in a DDSN Regional Center, DSN Board facility, other service provider facility, or during the direct provision of DDSN funded services (e.g., if a child receiving service coordination services sustains a serious injury while the service coordinator is in the child’s home, then it should be reported as a critical incident; however if the service coordinator is not in the home when the injury occurred then it would not be reported)”. An example of a critical incident includes but is not limited to possession of firearms, weapons or explosives or consumer accidents which result in serious injury requiring hospitalization or medical treatment from injuries received.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DSN Boards/contracted provider agencies are required to follow the SCDDSN policy specifically 534-02-DD, Procedures for Preventing and Reporting Abuse, Neglect or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency and 100-09-DD, Reporting of Critical Incidents. When a mandated reporter of the agency(s) suspects any abuse, neglect or exploitation they are required to make a report to the state agency(s) having statutory authority to receive and investigate the report.

In accordance with directives 100-09-DD, Reporting of Critical Incidents, 505-02-DD, Death or Impending Death of Person Residing in a Residential Program Sponsored by DDSN and 534-02-DD, Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider, DDSN Division of Quality Management provided training to providers in November and December 2007. In accordance with Policy Directive 567-01-DD, Pre-service Training Requirements and Orientation, DSN Board/contracted providers must provide training at least annually regarding prevention of abuse, neglect and exploitation. Competency is demonstrated with a combination of written tests and skills checks.

Waiver recipients will be provided written information about reporting abuse, neglect and exploitation. Annually, Waiver recipients will receive information about reporting abuse, neglect and exploitation. The information will be provided by Service Coordinators and will explain who is a vulnerable adult, what is abuse, and providers' phone numbers of where to report suspected abuse cases if they occur in a private home or nursing home.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When there is reason to believe that a child has been abused, neglected, or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. DSS is the mandated agency to investigate suspected abuse, neglect, or exploitation in these settings. DDSN/DHHS and its contract provider agencies shall be available to provide information and assistance to DSS. Procedures have been established for DDSN/DHHS to assist contract provider agencies in resolving issues with DSS regarding intake referrals and investigations. DSS will conduct a complete investigation and contact law enforcement if criminal violations are suspected. If the investigation is substantiated, notification is sent to appropriate agencies for personnel and other required actions to be taken. If the alleged perpetrator is also employed by DDSN or DHHS, a contract provider agency, or the family and abuse, neglect, or exploitation is substantiated, the employee will be terminated. When there is reason to believe that an adult has been abused, neglected or exploited in any residential program regardless of location, mandated reporters have a duty to make a report to the State Law Enforcement Department (SLED). If a suspected abuse occurs in any setting other than a home operated by or contracted for operation by DDSN, a report should be made to the County DSS (Adult Protective Services). DDSN works closely with SLED regarding critical events and/or incidents. In addition, critical incidents occurring at DDSN regional centers, DSN Board facilities, other service provider location, or while a consumer is under the supervision of staff or a contracted employee from an aforementioned provider, shall be reported to the Director, Division of Quality Management with DDSN. On a regular basis DDSN quality management staff will review critical incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. Statewide trend data will be provided to regional centers, DSN Boards and contracted service providers to enhance awareness activities as a prevention strategy. Each regional center, DSN Board or contracted service provider will also utilize their respective risk managers and committees to regularly review all critical incidents for trends and to determine if the recommendations made in the final written reports were actually implemented and are in effect.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DSS Child Protective Services and local and state law enforcement are responsible for overseeing the reporting of and response to critical incidents. In addition to investigations by the State Ombudsman, DSS, and law enforcement, other agencies have jurisdiction to make inquiry into incidents of abuse, neglect, or exploitation and may conduct their own investigation. These agencies include:

SLED/Child Fatalities Review Office
The Child Fatalities Review Office of the State Law Enforcement Division will investigate all deaths involving abuse, physical and sexual trauma as well as suspicious and questionable deaths of children. The State Child Fatalities Review Office will also review the involvement that various agencies may have had with the child prior to death.

Protection and Advocacy for People with Disabilities, Inc.
Protection and Advocacy for People with Disabilities (P&A) has statutory authority to investigate abuse and neglect of people with disabilities.

In addition, the DDSN Division of Quality Management maintains information on the incidence of abuse, neglect, or exploitation, including trend analyses to identify and respond to patterns of abuse, neglect, or exploitation. All data collected is considered confidential and is used in developing abuse prevention programs. All reports of abuse, neglect or exploitation are reviewed for consistency and completeness to assure the victim is safe, and to take immediate personnel action. DDSN requires that all identified alleged perpetrators be placed on administrative leave without pay until the investigation is completed. Periodic audits of the abuse reporting system are conducted to ensure compliance with state law.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

- **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

  The operating agency (DDSN) is responsible for oversight. DDSN contracts with the service coordination provider to monitor the Support Plan which includes asking the participant and their representative their satisfaction with service delivery on an ongoing basis. This plan will be reviewed by the Service Coordinator and the operating agency prior to implementation to ensure it does not contain any restraint or seclusion interventions.

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  The operating agency (DDSN) is responsible for oversight. DDSN contracts with the service coordination provider to monitor the Support Plan which includes asking the participant and their representative their satisfaction with service delivery on an ongoing basis. This plan will be reviewed by the Service Coordinator and the operating agency prior to implementation to ensure it does not contain any restraint or seclusion interventions.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DDSN has policies and standards that must be followed by DSN Board provider agencies/contracted providers. DSN Board/contracted service provider staff/quality assurance and management staff are responsible for monitoring to assure policies and standards are being met.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DDSN has standards and policies that must be followed by all DSN Boards/provider agencies. DSN Boards/provider agencies including quality assurance and management staff are responsible for adherence to standards and policies. DSN Boards/provider agencies are responsible for recording medication errors/events DDSN may request and review the data collected at any time. Critical incidents must be reported to DDSN and are reviewed by DDSN staff. The outcome data is analyzed and reviewed with recommended changes or training.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Policy Directive 100-29-DD, “Medication Error/Event Reporting”, Policy Directive 603-11-DD, “Monitoring Psychopharmacologic and Antiepileptic Medication for Side Effects”, Policy Directive 603-13-DD, “Medication Technician Certification and Policy Directive 1000-09-DD, “Reporting of Critical Incidents” are utilized by DDSN provider agencies.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report**

medication errors to a State agency (or agencies).

Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

South Carolina Department of Disabilities and Special Needs. Medication errors (such as naming, compounding packaging, etc.) that are outside the control of DDSN and its network of service providers must be reported to the pharmacist in order for corrective action to occur.

(b) Specify the types of medication errors that providers are required to *record:*

In Policy Directive 100-29-DD medication errors include the following: wrong person given a medication, wrong medication given, wrong dosage given, wrong route of administration, wrong time, medication not given by staff (i.e. omission) and medication given without a prescriber's order. Other medication errors include: transcription and documentation errors and "red flag" events. Red flag events include the following: a person refuses medication, a "near miss" where a medication error almost occurred, unsafe circumstances and when a discarded medication is found for example on the floor, etc.

(c) Specify the types of medication errors that providers must *report* to the State:

Bona fide or "true" medication errors, transcription and documentation errors and "red flag" events.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DSN Boards/contracted provider agencies/South Carolina Department of Disabilities and Special Needs.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and proportion of incidents of reported abuse, neglect, and exploitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of incidents of abuse, neglect, or exploitation that are reported within required timeframes.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval = [ ]
☐ **Other** Specify: [ ]	☐ **Annually**	☐ **Stratified** Describe Group: [ ]
	☑ **Continuously and Ongoing**	☐ **Other** Specify: [ ]
	☐ **Other** Specify: [ ]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify: [ ]	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify: [ ]

Performance Measure:
Number of incidents of abuse, neglect, or exploitation in which the internal review was completed within required timeframe.

Data Source (Select one):
Other

If 'Other' is selected, specify:
DDSN reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and proportion of substantiated incidents of abuse, neglect, and exploitation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

As abuse, neglect, and exploitation are identified, action is taken to protect the health and welfare of the participant.

Data is collected and analyzed for trends, and strategies are developed and implemented to prevent future occurrences.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The objective of the State's Quality Management Systems is to quickly and reliably identify, with strong confidence, both positive and adverse trends allowing for necessary adjustments to enhance the overall performance of the system. The State's system improvement activities are purposefully designed to ensure that they are across all six (6) CMS assurances – functioning effectively and efficiently based on performance measures. Data undergoes rigorous reliability and validity testing to ensure that the aggregated information used to drive policy and procedures decisions will yield their intended increased performance. Timely analyzed discovery and remediation aggregated data allows the state to take the necessary action to improve the system's performance, thereby learning how to improve meaningful outcomes for participants in the home and community based waivers administered by SCDHHS and operated by SCDDSN. The state is able to stratify information related to each approved waiver program and is also able to stratify by provider, service group, and assurance. Because the State's Quality Management System was designed several years ago with adjustments made as needed to ensure its overall effectiveness, to include aligning it to the CMS quality frame work, we have strong formal processes and activities in place for trending, prioritizing, and implementing system improvements. SCDDSN is continuously reviewing and updating its QMS processes to ensure it is responsive to the quality assurances.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

SCDHHS and SCDDSN meet periodically to monitor the need for any system design changes. Any changes recommended to the overall system's design or to any sub-systems are brought to the SCDHHS/SCDDSN Policy Committee for discussion/action.

SCDDSN is considering the development of an advisory stakeholder group to seek input and comment regarding needed changes or improvements. Additionally, SCDDSN will conduct public forums annually regarding aspects of the HASCI waiver program.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Each year, SCDDSN quality improvement organization conducts two (2) studies using random sampling regression analysis techniques to determine if the state's quality management system is performing as expected. It helps us to determine if modifications made to the system's design yield the intended results.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State employs several methods to ensure the integrity of payments made for Waiver services in different departments within the agency. Following are descriptions of the methods employed:

The State has a Memorandum of Agreement with the operating agency, DDSN, to assure provider qualifications for the provision of HASCI Waiver services and Service Coordination. DDSN maintains a quality review process utilizing their quality assurance contractor to ensure provider qualifications are valid and appropriate. The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff members at different levels to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and all other specified requirements. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

The Division of Program Integrity at DHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to service providers. Issues that involve fraudulent billing by providers are turned over to the Medicaid Fraud Control Unit in the South Carolina Attorney General's Office. In addition, the Division of Audits reviews DHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged.

Each DSN Board is required to perform a yearly audit of their financial position. These yearly audits are performed by independent CPA firms to determine if provider agencies are upholding general accepted accounting practices and are maintaining a sound financial position.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Proportion of paid claims that are coded and paid in accordance with policies in the approved waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN web based adjustments

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN/QIO Adjustment Logs

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-15%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
RSP Indicators

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDHHS Reviews/Investigations

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-10%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
SCDDSN's Internal Audit Division does periodic reviews of the billing system and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with SCDHHS in a timely manner.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
SCDDSN voids and/or replaces claims as errors when identified. SCDDSN reviews and amends its financial policy and procedures upon review and approval by SCDHHS. Additionally, SCDHHS may perform manual adjustments to address problems as they are discovered. Financial policies may be revised to ensure SCDDSN prevents future occurrences of similar errors.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Periodic

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Bureau of Reimbursement Methodology and Policy, with assistance from DDSN, is responsible for the development of Waiver service payment rates. The Bureau of Reimbursement Methodology operates under the direction of the South Carolina Department of Health and Human Services. The Medicaid agency allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public hearings, or through meetings with association representatives.

Waiver service rates were established based upon the projected costs of the service to be provided. Projected costs used in the determination of the Waiver rates would include salaries, fringe benefits, travel, training, and applicable overhead costs (which is less than 10%). Billable hours were determined in order to adjust for time spent on leave, training, travel, and administration. Both DDSN and the Bureau of Reimbursement Methodology perform financial reviews on an as needed basis to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services.

The Service Coordination service rates provided to Waiver participants were based upon the projected costs of the service to be provided and adjusted for patient caseload. Projected costs used in the determination of the Waiver rates would include salaries, fringe benefits, travel, training, and the applicable overhead costs (which is less than 10%). Billable hours were determined in order to adjust for time spent on leave, training, travel, and administration. The reasonableness of the Service Coordination rate developed was determined by comparing the rate against private provider Service Coordination/Case Management rates for children/adults similar to those enrolling in the Waiver.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers maintain the option of billing directly to the Medicaid agency or they may voluntarily reassign their right to direct payments to the Department of Disabilities and Special Needs. Providers billing Medicaid directly may bill either by use of a CMS 1500 form or by the State's electronic billing system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ○ **No. State or local government agencies do not certify expenditures for waiver services.**
- ◉ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

- ☑ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51 (b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

(a) – The South Carolina Department of Disabilities and Special Needs (SCDDSN). (b) – SCDDSN files annual cost reports that report the total costs incurred for both their institutional services (i.e. ICF/MRs) and all Waiver services providers. (c) – The SCDDSN received $6.7 million in state appropriations for these services in SFY 2009/2010. The contract between SCDHHS and SCDDSN applicable to these services will require the following contract language:

"SCDDSN agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable, and necessary cost for the provision of services to be provided to Medicaid recipients under the contract prior to submitting claims under the contract." Additionally, the Internal Audit Division within the SCDHHS has included in its' audit plan planned audits of State

Agency Medicaid contracts.

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for Waiver services are submitted to MMIS through either the use of a CMS 1500 form or through the State's electronic billing system. Providers of Waiver services are given a service authorization, which reflects the service identified on the Support Plan. This authorization is produced by the Service Coordinator and contains the frequency, date and type of service authorized along with a unique authorization number. Once the claim is submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is an indication in MMIS that the participant is enrolled in the Waiver program. This is the case for all claims.

The DHHS Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized.

The DDSN internal audit division periodically conducts audits of DDSN's billing system to ensure billing is appropriate for the service provided.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which

system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

  A financial management services (FMS) entity is used to make payments for in-home services delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. This information is transferred to DDSN, which in turn bills MMIS for services rendered. The FMS cuts checks biweekly and transfers funds to workers by direct deposit. Financial audits are performed periodically.
- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

  Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

  Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these

payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

SCDDSN will be reimbursed retrospectively for its total allowable Medicaid costs incurred of providing services under this Waiver. Therefore, the supplemental payment will equate to a cost settlement that will be determined upon the completion of the SCDHHS review of the annual cost report submitted by the SCDDSN.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

SCDDSN will receive payment for waiver services and will provide the following waiver services: UAP Attendant Care services to include any DSN Board billed Waiver services and Service Coordination.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ◉ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

SCDDSN will submit annual cost reports that reflect the total costs incurred by SCDDSN and/or its local Boards of the services provided under this Waiver. The SCDHHS will desk review the cost report and determine the average unit cost of the services provided under this Waiver based upon costs and units of the total population served (ie., both Medicaid and non-Medicaid recipients). The actual cost rate will then be compared against the interim rate paid to determine an overpayment or underpayment. If an overpayment occurs, the SCDHHS will recoup the federal portion of the

overpayment from the SCDDSN and return it to CMS via the quarterly expenditure report.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- (●) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

The Department of Disabilities and Special Needs

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) DDSN operates as an organized health care delivery system (OHCDS). This system of care is comprised of DDSN and the local DSN County Boards and together they form an OHCDS. The OHCDS establishes contracts with other qualified providers to furnish home and community based services to people served in this waiver. (b)

Providers of Waiver services may direct bill their services to DHHS. (c) At a minimum, Waiver participants are given a choice of providers, regardless of their affiliate with the OHCDS, annually or more frequent if requested or warranted (d) DDSN will assure that providers that furnish Waiver services under contract with the OHCDS meet applicable provider qualifications through the state's procurement process. (e) DDSN assures that contracts with providers meet applicable requirements via an annual quality assurance review of the provider, as well as periodic record reviews. (f) DDSN requires its local DSN County Boards to perform annual financial audits.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [ ] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The South Carolina Department of Disabilities and Special Needs (SCDDSN) received state appropriations to provide services under this Waiver. A portion of these funds will be transferred to the South Carolina Department of Health and Human Services (SCDHHS) via an Interdepartmental Transfer (IDT) for payments that will be made directly to private providers enrolled with the SCDHHS. For services provided by SCDDSN, these funds will be directly expended by SCDDSN as CPE.

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (•) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (•) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

This Head and Spinal Cord Injury waiver has only one service, residential habilitation, in which room and board could be included in the service. Continual monitoring and training is provided to assure that room and board costs are excluded. Through the annual audits, financial testing of residential cost is performed by independent CPA firms to assure that room and board costs are excluded from Medicaid payment.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - **i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility, ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	28190.62	9935.00	38125.62	43894.00	7452.00	51346.00	13220.38
2	27630.17	10233.00	37863.17	45211.00	7676.00	52887.00	15023.83
3	28540.83	10540.00	39080.83	46567.00	7906.00	54473.00	15392.17
4	29293.34	10856.00	40149.34	47964.00	8143.00	56107.00	15957.66
5	29619.09	11182.00	40801.09	49403.00	8388.00	57791.00	16989.91

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Nursing Facility	Level of Care: ICF/MR
Year 1	788	772	16
Year 2	842	825	17
Year 3	892	874	18
Year 4 (renewal only)	945	926	19
Year 5 (renewal only)	998	978	20

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Year 1 - 11.09 months; 333 days
Year 2 - 11.12 months; 334 days
Year 3 - 11.15 months; 335 days
Year 4 - 11.18 months; 336 days
Year 5 - 11.21 months; 337 days

This derivation is based on current 372 data with an inflation factor of 5% built in to account for increases in enrollments over the last two years of the preceeding waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates are based on projected utilization of services. The projected utilizations are based on current industry practices for each service level included in the waiver. The costs per services were determined by surveying current provider of services.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The derivation of the figures originate with the CMS 372 Report for Waiver #0284.01.R1 for the year ending 6/30/2007 with an inflation factor of 5% for year one and 3% for year two through year five.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

2007 ICF/MR cost Reports and the 2008 Preliminary Cost Reports. The 2007 Cost Report is on file at the Department of Health and Human Services.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The derivation of the figures originate with the CMS 372 Report for Waiver #0284.01.R1 for the year ending 6/30/2007 with an inflation factor of 5% for year one and 3% for year two through year five.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Attendant Care/Personal Assistance Services
Day Habilitation

Prevocational Services
Residential Habilitation
Respite Care Services
Supported Employment Services
Occupational Therapy
Physical Therapy
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.
Speech, hearing and language services
Behavioral Support Services
Environmental Modifications
Health Education for Consumer-Directed Care
Medicaid Waiver Nursing
Medical Supplies, Equipment and Assistive Technology
Peer Guidance for Consumer-Directed Care
Personal Emergency Response Systems
Private Vehicle Modifications
Psychological Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Services Total:						**13590745.60**
Self Directed	Per Hour	142	1856.00	14.30	**3768793.60**	
Agency/Board Billed	Per Hour	315	1856.00	16.80	**9821952.00**	
Day Habilitation Total:						**121024.00**
Day Habilitation	Per Day	16	244.00	31.00	**121024.00**	
Prevocational Services Total:						**121024.00**
Prevocational Services	Per Day	16	244.00	31.00	**121024.00**	
Residential Habilitation Total:						**3271200.00**
Residential Habilitation	Per Day	47	348.00	200.00	**3271200.00**	
Respite Care Services Total:						**985058.20**

Institutional NF/Hospital Based	Per Day	8	35.00	130.00	**36400.00**	
Institutional ICF/MR Based	Per Day	8	35.00	250.00	**70000.00**	
Non Institutional Based	Per Hour	158	383.00	8.30	**502266.20**	
CRCF Based	Per Day	8	23.00	50.00	**9200.00**	
Non Institutional Based	Per Day	158	35.00	66.40	**367192.00**	
Supported Employment Services Total:						**15036.48**
Supported Employment Services	Per Hour	16	46.00	20.43	**15036.48**	
Occupational Therapy Total:						**33600.00**
Occupational Therapy	Per Hour	8	70.00	60.00	**33600.00**	
Physical Therapy Total:						**22080.00**
Physical Therapy	Per Hour	8	46.00	60.00	**22080.00**	
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits. Total:						**164150.00**
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	Per Item	134	35.00	35.00	**164150.00**	
Speech, hearing and language services Total:						**51520.00**
Audiologist	Per Hour	8	46.00	60.00	**22080.00**	
Speech Language Pathologist	Per Hour	8	46.00	40.00	**14720.00**	
Speech Therapist	Per Hour	8	46.00	40.00	**14720.00**	
Behavioral Support Services Total:						**44160.00**
Behavioral Support Services	Per Hour	16	46.00	60.00	**44160.00**	
Environmental Modifications Total:						**564000.00**
Environmental Modifications	Per Item	47	1.00	12000.00	**564000.00**	
Health Education for Consumer-Directed Care Total:						**5760.00**
Health Education for Consumer Directed Care	Per Unit	24	12.00	20.00	**5760.00**	
Medicaid Waiver Nursing Total:						**1275573.00**
Licensed Practical Nurse	Per Hour	39	742.00	25.00	**723450.00**	
Registered Nurse	Per Hour	39	429.00	33.00	**552123.00**	
Medical Supplies, Equipment and Assistive Technology Total:						**1082500.00**
Medical Supplies, Equipment and Assistive Technology	Per Item	433	25.00	100.00	**1082500.00**	
Peer Guidance for Consumer-Directed Care Total:						**5760.00**
Peer Guidance for Consumer-Directed Care	Per Unit	24	12.00	20.00	**5760.00**	

Personal Emergency Response Systems Total:						**73260.00**
Recurring Maintenance	Per Item	165	12.00	36.00	**71280.00**	
Initial Installation	Per Item	55	1.00	36.00	**1980.00**	
Private Vehicle Modifications Total:						**702000.00**
Private Vehicle Modifications	Per Item	39	1.00	18000.00	**702000.00**	
Psychological Services Total:						**85760.00**
Drug/Alcohol Counseling	Per Hour	16	46.00	40.00	**29440.00**	
Counseling Services	Per Hour	16	46.00	60.00	**44160.00**	
Evaluation/Testing	Per Assessment	16	1.00	760.00	**12160.00**	
			GRAND TOTAL:			**22214211.28**
			Total Estimated Unduplicated Participants:			**788**
			Factor D (Divide total by number of participants):			**28190.62**
			Average Length of Stay on the Waiver:			333

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Services Total:						**13938820.80**
Self Directed	Per Hour	152	1779.00	14.30	**3866834.40**	
Agency/Board Billed	Per Hour	337	1779.00	16.80	**10071986.40**	
Day Habilitation Total:						**128588.00**
Day Habilitation	Per Day	17	244.00	31.00	**128588.00**	
Prevocational Services Total:						**128588.00**
Prevocational Services	Per Day	17	244.00	31.00	**128588.00**	
Residential Habilitation Total:						**3559800.00**
Residential Habilitation	Per Day	51	349.00	200.00	**3559800.00**	
Respite Care Services Total:						**1041481.60**

Institutional NF/Hospital Based	Per Day	8	35.00	130.00	**36400.00**	
Institutional ICF/MR Based	Per Day	8	35.00	250.00	**70000.00**	
Non Institutional Based	Per Hour	168	384.00	8.30	**535449.60**	
CRCF Based	Per Day	8	23.00	50.00	**9200.00**	
Non Institutional Based	Per Day	168	35.00	66.40	**390432.00**	
Supported Employment Services Total:						**16323.57**
Supported Employment Services	Per Hour	17	47.00	20.43	**16323.57**	
Occupational Therapy Total:						**33600.00**
Occupational Therapy	Per Hour	8	70.00	60.00	**33600.00**	
Physical Therapy Total:						**22560.00**
Physical Therapy	Per Hour	8	47.00	60.00	**22560.00**	
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits. Total:						**175175.00**
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	Per Item	143	35.00	35.00	**175175.00**	
Speech, hearing and language services Total:						**52640.00**
Audiologist	Per Hour	8	47.00	60.00	**22560.00**	
Speech Language Pathologist	Per Hour	8	47.00	40.00	**15040.00**	
Speech Therapist	Per Hour	8	47.00	40.00	**15040.00**	
Behavioral Support Services Total:						**76140.00**
Behavioral Support Services	Per Hour	27	47.00	60.00	**76140.00**	
Environmental Modifications Total:						**612000.00**
Environmental Modifications	Per Item	51	1.00	12000.00	**612000.00**	
Health Education for Consumer-Directed Care Total:						**8400.00**
Health Education for Consumer Directed Care	Per Unit	35	12.00	20.00	**8400.00**	
Medicaid Waiver Nursing Total:						**1377180.00**
Licensed Practical Nurse	Per Hour	42	744.00	25.00	**781200.00**	
Registered Nurse	Per Hour	42	430.00	33.00	**595980.00**	
Medical Supplies, Equipment and Assistive Technology Total:						**1157500.00**
Medical Supplies, Equipment and Assistive Technology	Per Item	463	25.00	100.00	**1157500.00**	
Peer Guidance for Consumer-Directed Care Total:						**8400.00**
Peer Guidance for Consumer-Directed Care	Per Unit	35	12.00	20.00	**8400.00**	

Personal Emergency Response Systems Total:						**78588.00**
Recurring Maintenance	Per Item	177	12.00	36.00	**76464.00**	
Initial Installation	Per Item	59	1.00	36.00	**2124.00**	
Private Vehicle Modifications Total:						**756000.00**
Private Vehicle Modifications	Per Item	42	1.00	18000.00	**756000.00**	
Psychological Services Total:						**92820.00**
Drug/Alcohol Counseling	Per Hour	17	47.00	40.00	**31960.00**	
Counseling Services	Per Hour	17	47.00	60.00	**47940.00**	
Evaluation/Testing	Per Assessment	17	1.00	760.00	**12920.00**	

GRAND TOTAL:	**23264604.97**
Total Estimated Unduplicated Participants:	**842**
Factor D (Divide total by number of participants):	**27630.17**
Average Length of Stay on the Waiver:	334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Services Total:						**15231876.66**
Self Directed	Per Hour	161	1782.00	14.73	**4226066.46**	
Agency/Board Billed	Per Hour	357	1782.00	17.30	**11005810.20**	
Day Habilitation Total:						**158980.50**
Day Habilitation	Per Day	18	245.00	36.05	**158980.50**	
Prevocational Services Total:						**158980.50**
Prevocational Services	Per Day	18	245.00	36.05	**158980.50**	
Residential Habilitation Total:						**3893400.00**
Residential Habilitation	Per Day	54	350.00	206.00	**3893400.00**	
Respite Care Services Total:						**1144430.80**

Institutional NF/Hospital Based	Per Day	9	35.00	133.90	**42178.50**	
Institutional ICF/MR Based	Per Day	9	35.00	257.50	**81112.50**	
Non Institutional Based	Per Hour	178	384.00	8.55	**584409.60**	
CRCF Based	Per Day	9	23.00	51.50	**10660.50**	
Non Institutional Based	Per Day	178	35.00	68.39	**426069.70**	
Supported Employment Services Total:						**17799.84**
Supported Employment Services	Per Hour	18	47.00	21.04	**17799.84**	
Occupational Therapy Total:						**38934.00**
Occupational Therapy	Per Hour	9	70.00	61.80	**38934.00**	
Physical Therapy Total:						**26141.40**
Physical Therapy	Per Hour	9	47.00	61.80	**26141.40**	
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits. Total:						**197372.00**
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	Per Item	152	35.00	37.10	**197372.00**	
Speech, hearing and language services Total:						**60996.60**
Audiologist	Per Hour	9	47.00	61.80	**26141.40**	
Speech Language Pathologist	Per Hour	9	47.00	41.20	**17427.60**	
Speech Therapist	Per Hour	9	47.00	41.20	**17427.60**	
Behavioral Support Services Total:						**110374.80**
Behavioral Support Services	Per Hour	38	47.00	61.80	**110374.80**	
Environmental Modifications Total:						**648000.00**
Environmental Modifications	Per Item	54	1.00	12000.00	**648000.00**	
Health Education for Consumer-Directed Care Total:						**11618.40**
Health Education for Consumer Directed Care	Per Unit	47	12.00	20.60	**11618.40**	
Medicaid Waiver Nursing Total:						**1523663.55**
Licensed Practical Nurse	Per Hour	45	746.00	25.75	**864427.50**	
Registered Nurse	Per Hour	45	431.00	33.99	**659236.05**	
Medical Supplies, Equipment and Assistive Technology Total:						**1227500.00**
Medical Supplies, Equipment and Assistive Technology	Per Item	491	25.00	100.00	**1227500.00**	
Peer Guidance for Consumer-Directed Care Total:						**11618.40**
Peer Guidance for Consumer-Directed Care	Per Hour	47	12.00	20.60	**11618.40**	

Personal Emergency Response Systems Total:						**85506.48**
Recurring Maintenance	Per Item	187	12.00	37.08	**83207.52**	
Initial Installation	Per Item	62	1.00	37.08	**2298.96**	
Private Vehicle Modifications Total:						**810000.00**
Private Vehicle Modifications	Per Item	45	1.00	18000.00	**810000.00**	
Psychological Services Total:						**101228.40**
Drug/Alcohol Counseling	Per Hour	18	47.00	61.80	**52282.80**	
Counseling Services	Per Hour	18	47.00	41.20	**34855.20**	
Evaluation/Testing	Per Assessment	18	1.00	782.80	**14090.40**	
				GRAND TOTAL:		**25458422.33**
				Total Estimated Unduplicated Participants:		**892**
				Factor D (Divide total by number of participants):		**28540.83**
				Average Length of Stay on the Waiver:		335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Services Total:						**16636339.96**
Self Directed	Per Hour	170	1786.00	15.17	**4605915.40**	
Agency/Board Billed	Per Hour	378	1786.00	17.82	**12030424.56**	
Day Habilitation Total:						**172840.15**
Day Habilitation	Per Day	19	245.00	37.13	**172840.15**	
Prevocational Services Total:						**172840.15**
Prevocational Services	Per Day	19	245.00	37.13	**172840.15**	
Residential Habilitation Total:						**4232991.00**
Residential Habilitation	Per Day	57	350.00	212.18	**4232991.00**	
Respite Care Services Total:						**1244993.85**

Institutional NF/Hospital Based	Per Day	9	35.00	137.92	**43444.80**	
Institutional ICF/MR Based	Per Day	9	35.00	265.23	**83547.45**	
Non Institutional Based	Per Hour	189	385.00	8.81	**641059.65**	
CRCF Based	Per Day	9	23.00	53.05	**10981.35**	
Non Institutional Based	Per Day	189	35.00	70.44	**465960.60**	
Supported Employment Services Total:						**19351.31**
Supported Employment Services	Per Hour	19	47.00	21.67	**19351.31**	
Occupational Therapy Total:						**40099.50**
Occupational Therapy	Per Hour	9	70.00	63.65	**40099.50**	
Physical Therapy Total:						**26923.95**
Physical Therapy	Per Hour	9	47.00	63.65	**26923.95**	
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits. Total:						**221624.55**
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	Per Item	161	35.00	39.33	**221624.55**	
Speech, hearing and language services Total:						**62828.19**
Audiologist	Per Hour	9	47.00	63.65	**26923.95**	
Speech Language Pathologist	Per Hour	9	47.00	42.44	**17952.12**	
Speech Therapist	Per Hour	9	47.00	42.44	**17952.12**	
Behavioral Support Services Total:						**146585.95**
Behavioral Support Services	Per Hour	49	47.00	63.65	**146585.95**	
Environmental Modifications Total:						**684000.00**
Environmental Modifications	Per Item	57	1.00	12000.00	**684000.00**	
Health Education for Consumer-Directed Care Total:						**14769.12**
Health Education for Consumer Directed Care	Per Unit	58	12.00	21.22	**14769.12**	
Medicaid Waiver Nursing Total:						**1641933.72**
Licensed Practical Nurse	Per Hour	47	747.00	26.52	**931090.68**	
Registered Nurse	Per Hour	47	432.00	35.01	**710843.04**	
Medical Supplies, Equipment and Assistive Technology Total:						**1300000.00**
Medical Supplies, Equipment and Assistive Technology	Per Item	520	25.00	100.00	**1300000.00**	
Peer Guidance for Consumer-Directed Care Total:						**14769.12**
Peer Guidance for Consumer-Directed Care	Per Unit	58	12.00	21.22	**14769.12**	

Personal Emergency Response Systems Total:						**93259.98**
Recurring Maintenance	Per Item	198	12.00	38.19	**90739.44**	
Initial Installation	Per Item	66	1.00	38.19	**2520.54**	
Private Vehicle Modifications Total:						**846000.00**
Private Vehicle Modifications	Per Item	47	1.00	18000.00	**846000.00**	
Psychological Services Total:						**110057.69**
Drug/Alcohol Counseling	Per Hour	19	47.00	42.44	**37898.92**	
Counseling Services	Per Hour	19	47.00	63.65	**56839.45**	
Evaluation/Testing	Per Assessment	19	1.00	806.28	**15319.32**	

GRAND TOTAL:	**27682208.19**
Total Estimated Unduplicated Participants:	**945**
Factor D (Divide total by number of participants):	**29293.34**
Average Length of Stay on the Waiver:	336

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care/Personal Assistance Services Total:						**17764125.96**
Self Directed	Per Hour	176	1789.00	15.63	**4921324.32**	
Agency/Board Billed	Per Hour	391	1789.00	18.36	**12842801.64**	
Day Habilitation Total:						**187425.00**
Day Habilitation	Per Day	20	245.00	38.25	**187425.00**	
Prevocational Services Total:						**187425.00**
Prevocational Services	Per Day	20	245.00	38.25	**187425.00**	
Residential Habilitation Total:						**4525951.95**
Residential Habilitation	Per Day	59	351.00	218.55	**4525951.95**	
Respite Care Services Total:						**1341859.22**

Institutional NF/Hospital Based	Per Day	10	35.00	142.05	**49717.50**	
Institutional ICF/MR Based	Per Day	10	35.00	273.18	**95613.00**	
Non Institutional Based	Per Hour	196	386.00	9.07	**686199.92**	
CRCF Based	Per Day	10	23.00	54.64	**12567.20**	
Non Institutional Based	Per Day	196	35.00	72.56	**497761.60**	
Supported Employment Services Total:						**20980.80**
Supported Employment Services	Per Hour	20	47.00	22.32	**20980.80**	
Occupational Therapy Total:						**45892.00**
Occupational Therapy	Per Hour	10	70.00	65.56	**45892.00**	
Physical Therapy Total:						**30813.20**
Physical Therapy	Per Hour	10	47.00	65.56	**30813.20**	
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits. Total:						**242218.90**
Prescribed Drugs, except drugs furnished to participants under Medicare Part D benefits.	Per Item	166	35.00	41.69	**242218.90**	
Speech, hearing and language services Total:						**71900.60**
Audiologist	Per Hour	10	47.00	65.56	**30813.20**	
Speech Language Pathologist	Per Hour	10	47.00	43.71	**20543.70**	
Speech Therapist	Per Hour	10	47.00	43.71	**20543.70**	
Behavioral Support Services Total:						**184879.20**
Behavioral Support Services	Per Hour	60	47.00	65.56	**184879.20**	
Environmental Modifications Total:						**708000.00**
Environmental Modifications	Per Item	59	1.00	12000.00	**708000.00**	
Health Education for Consumer-Directed Care Total:						**18091.80**
Health Education for Consumer Directed Care	Per Unit	69	12.00	21.85	**18091.80**	
Medicaid Waiver Nursing Total:						**1766417.66**
Licensed Practical Nurse	Per Hour	49	748.00	27.32	**1001332.64**	
Registered Nurse	Per Hour	49	433.00	36.06	**765085.02**	
Medical Supplies, Equipment and Assistive Technology Total:						**1345000.00**
Medical Supplies, Equipment and Assistive Technology	Per Item	538	25.00	100.00	**1345000.00**	
Peer Guidance for Consumer-Directed Care Total:						**18091.80**
Peer Guidance for Consumer-Directed Care	Per Unit	69	12.00	21.85	**18091.80**	

Personal Emergency Response Systems Total:						**99451.52**
Recurring Maintenance	Per Item	205	12.00	39.34	**96776.40**	
Initial Installation	Per Item	68	1.00	39.34	**2675.12**	
Private Vehicle Modifications Total:						**882000.00**
Private Vehicle Modifications	Per Item	49	1.00	18000.00	**882000.00**	
Psychological Services Total:						**119323.20**
Drug/Alcohol Counseling	Per Hour	20	47.00	43.71	**41087.40**	
Counseling Services	Per Hour	20	47.00	65.56	**61626.40**	
Evaluation/Testing	Per Assessment	20	1.00	830.47	**16609.40**	

GRAND TOTAL:	**29559847.81**
Total Estimated Unduplicated Participants:	**998**
Factor D (Divide total by number of participants):	**29619.09**
Average Length of Stay on the Waiver:	337